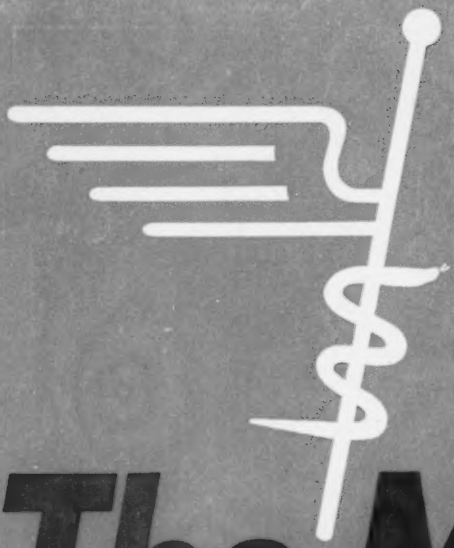
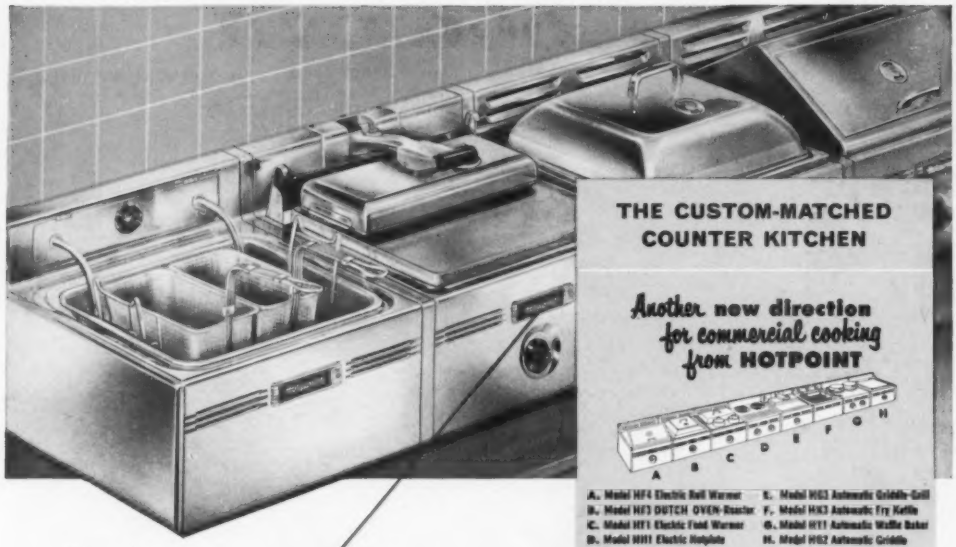


The Modern Hospital

AUGUST 1951

Labor gets rough in Minneapolis hospital strike • Formula for analyzing nursing service • The general practitioner and the community hospital • University of California Medical Center • Outline for institute on hospital operations • Life of St. Vincent de Paul



THE CUSTOM-MATCHED COUNTER KITCHEN

Another new direction for commercial cooking from **HOTPOINT**

A. Model HF4 Electric Roll Warmer
B. Model HF3 DUTCH OVEN-Roaster
C. Model HF1 Electric Food Warmer
D. Model HH1 Electric Hotplate
E. Model HG3 Automatic Griddle-Grill
F. Model HK3 Automatic Fry Kettle
G. Model HT1 Automatic Waffle Baker
H. Model HG2 Automatic Griddle

"Out in Front" ALL THE WAY!

"Out in Front" All the Way... In Beauty, Value, Performance and Sales! The Hotpoint Custom-Matched Counter Kitchen creates important NEW DIRECTIONS for "out front" counter cooking!

Combining brilliant add-a-unit styling with the most important advancements in modern cooking equipment... the glamorous Hotpoint Counter Kitchen creates BETTER WAYS TO COOK... makes many new cooking accomplishments now possible for the first time!

Here are just a few of the Signposts to NEW DIRECTIONS in Counter Cooking brought to you exclusively by Hotpoint—

The DUTCH OVEN-Roaster... that captures the magic of famous old Dutch Oven recipes. It roasts, bakes and stews... prepares delicious one-dish meals... and holds them at serving temperature.

The world's most-wanted Fry Kettle... with lift-out fat compartment to banish old-fashioned cleaning methods... and the famous Swing-Up Calrod® Unit that cuts fat use up to 60%.

The world's only Griddle-Grill, the amazing device that griddles and grills on the same appliance at the same time.

And today another Hotpoint NEW DIRECTION takes its place beside the host of remarkable developments that have made this the *King of Counter Lines*. It's the new Hotpoint Custom-Matched Roll Warmer, with exclusive built-in Flavor Retainer and Natural Freshener... scientifically engineered to keep rolls fresher—longer!

You will be amazed and delighted when you learn all about every superiority in every model in the superb Hotpoint Counter Line. These are the fullest, finest possibilities of commercial cooking—for today and for years to come! See for yourself how extraordinarily fine commercial cooking can be—how efficient and profitable your own operation can become with the Custom-Matched Hotpoint Counter Kitchen.

"The Hotpoint Counter Kitchen has helped us to increase business 930%!"
Wohl's Restaurant—St. Louis

SEND IN COUPON TODAY!

Hotpoint

HOTPOINT INC. A GENERAL ELECTRIC AFFILIATE

HOTPOINT INC.
Commercial Equipment Dept.
229 S. Sealey Ave., Chicago 12, Ill.

We'd like to see and hear about the new Custom-Matched Counter Kitchen.

Name_____

Firm_____ Title_____

Address_____

City_____ State_____

The Modern Hospital

EDITORIAL DIRECTOR: RAYMOND P. SLOAN
EDITOR: ROBERT M. CUNNINGHAM JR.
TECHNICAL ADVISER: EVERETT W. JONES
ASSOCIATE EDITORS: MILDRED WHITCOMB, JANE BARTON

PUBLISHER: OTHO F. BALL, M.D.
ASSOCIATE PUBLISHER: STANLEY R. CLAGUE
ADVERTISING DIRECTOR: J. W. CANNON JR.

AUGUST 1951

Published monthly and copyrighted, 1951. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill. U. S. A. (Cable Address: Modital, Chicago.) Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. Subscription price: to hospitals and allied fields, architects, medical schools, libraries in North and South America, $3 a year; overseas, $5 a year. Single copies, 35 cents; back copies, 50 cents to $1. Subscriptions from all others, $8 a year; single copies, $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A. Eastern Office, 101 Park Avenue, New York 17, N. Y. Pacific Coast Representatives, McDonald-Thompson, Los Angeles, San Francisco, Seattle, Fort Worth, Portland, Denver.

simplified

diabetic management through improved time-action and fewer injections

NPH ILETIN (INSULIN, LILLY)

For many diabetics taking two or more daily injections of other Insulin preparations, one daily injection of NPH Insulin will often be adequate for purposes of control. This improvement is a long stride toward a more nearly normal life.

For physicians, this development eliminates some of the obstacles which earlier stood in the way of satisfactory adjustment of doses to the patient's needs.

NPH ILETIN (INSULIN, LILLY)

Detailed information and literature concerning NPH Iletin (Insulin, Lilly) are personally supplied by your Lilly medical service representative or may be obtained by writing to

ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

AMONG THE AUTHORS


E. L. Geibel


J. E. Barnes

Edgar L. Geibel and **Joseph E. Barnes,** co-authors of the article on page 54 describing a new method of analyzing bedside nursing service, are assistant directors of the Genesee Hospital at Rochester, N.Y. Mr. Geibel is a graduate of the University of Pittsburgh who took his graduate training in hospital administration at the school of public health of Yale University and served his administrative residency at the Genesee Hospital.

Mr. Barnes is a graduate of Carnegie Institute of Technology and the graduate course in hospital administration of the University of Chicago. During the war he was a major in the army medical department, serving with the 99th Evacuation Hospital.


Dr. S. R. Truman

Dr. Stanley R. Truman, whose article on the general practitioner in the community hospital appears on page 100 of this issue, is himself a distinguished general practitioner—past president of the American Academy of General Practice and a member of the publication committee of the academy's journal, *GP.* A graduate of the University of California, Dr. Truman did postgraduate work at Union Theological Seminary, then returned to California and took a master's degree in psychology before entering medical school. After receiving his M.D. degree from the University of California, he took intern and residency training at the University Hospital in San Francisco and at the Highland Hospital in Oakland, where he now practices.


Louise Seymour

E. Louise Seymour is chief record librarian and director of the school for medical record librarians at Massachusetts General Hospital, Boston. She is also a vice president and member of the council on education of the American Association of Medical Record Librarians—an organization in which she has been active ever since she became secretary of the Philadelphia chapter 15 years ago, when she was a librarian on the staff of Philadelphia's Episcopal Hospital. A graduate of Maryland College for Women at Lutherville, Md., Miss Seymour also attended Boston University and was graduated from the school for record librarians at Philadelphia's Graduate Hospital. Before going to her present position she served as chief librarian at several hospitals in Baltimore and Washington, D.C.


Elizabeth Cole

Elizabeth Cole, director of the dietary department at Mountainside Hospital, Montclair, N.J., attended Battle Creek College in Battle Creek, Mich. After three years there, she transferred to Florida State University, Tallahassee, where she spent one year as student dietitian and also received the bachelor of science degree. She completed a dietetic internship at Columbia Medical Center in New York City. Hospitals at which she has served as assistant dietitian were Brooklyn Jewish, Albany and Montefiore in New York.

Roving Reporter

Community Sparks "Spirit" Into Hospital

We are rebuilding a hospital in San Antonio. The old Robert B. Green Memorial Hospital is to be enlarged to approximately 300 beds and completely modernized under a $3,000,000 improvement plan. The plans call for a new five-story wing, and other additions for surgery, emergency, clinical laboratory, x-ray, autopsy, main kitchen and storeroom. A new power and heating plant, a laundry annex, and a chest clinic annex recently have been completed.

In addition to the aforementioned units, the 150 bed tuberculosis sanatorium, recently completed approximately 12 miles from the city limits, is one of the most modern institutions of its kind, and is a part of our hospital.

One of the oldest community charity hospitals in Texas, the Robert B. Green Memorial Hospital closed its doors to the needy public during the summer of 1947 because of lack of funds. In July 1947, the training school for nurses was closed and all students transferred to other hospitals. Interns dropped off and residents resigned, until at the end of the year only one resident and one intern remained. There were eight small medical staff meetings in 1947, and on Sept. 23, 1947, the staff met for the last time, then disbanded.

This condition continued until the first of 1948 when the new board of managers was selected and approved by the commissioner's court—seven men representing the Chamber of Commerce, the Junior Chamber of Commerce, the Mexican Chamber of Commerce, the Bexar County Medical Society, the Bexar County Dental Society, the Society of Pharmacists, and the San Antonio Medical Foundation.

The newly appointed board inherited the control of the Robert B. Green Memorial Hospital—closed, cold and dark—with skeleton personnel and a few old bedfast chronic patients, and an operating cash balance of $36,385.96. The board immediately began making plans for the reopening and operation of the hospital early in 1948. The maternity section and tumor ward for indigent cancer patients were opened early in the year, and the pediatrics ward for infant diahrrea was opened in July 1948.

Goldman S. Drury, administrator of the City-County Hospital in Fort Worth, was appointed director and plans were made for the reorganization of the medical staff and the reopening of the hospital to full service. On June 29, 1949, the medical staff was reorganized, officers elected and complete staff assignments were made according to service. In October of 1949 the hospital, which had by then lost all standing with the American Medical Association, was approved for intern training by the Council on Medical Education and Hospitals. In relatively quick succession came approval by the American College of Surgeons, the establishment of a postgraduate school of medicine by the University of Texas, and approval for a three-year residency in general surgery by the American Board of Surgery, American Medical Associaton Council on Hospitals and Education, and the American College of Surgeons. Other

applications and approvals are pending.

Since the return of the interns and residents on July 1, 1951, this has been a busy hospital. Emergency rooms are busy on a 24 hour a day basis; children's, men's and women's wards are filled, and 50 clinics are conducted weekly, providing care and treatment for an average of 3500 persons a month.

One hundred and fifty leading doctors serve on the attending staff and donate their time to ensure the highest type of diagnostic and therapeutic care. Nine residents and 12 interns are now a part of the hospital staff.

Everywhere there is a new spirit in the old building for in one year Robert B. Green Memorial Hospital in San Antonio has achieved satisfactory improvement in the state of its institutional health, and, in what some Bexar County leaders described as their "finest demonstration of civic pride," civic leaders and civic and welfare organizations by the score, acting under impetus provided by the Community Welfare Council, have rallied public support for full operation of Bexar County's only charity hospital.

Operated under the direction of a board of managers, most of the hospital's progress is attributed by Angus Cockrell, board chairman, to the fact that political interference has been completely eliminated.

"Some people found it hard to believe that politics could be eliminated from a public institution, supported by public funds," Mr. Cockrell observed. "Developments of the past year prove that it can be done."

The board seems to have achieved a happy combination of sound business principles with humane considerations. Taxpayers of Bexar County and the city of San Antonio are proud of the fact that within the first 10 months of full operation, 39,528 men, women and children came to the hospital for help—and received help. This was an average of almost 4000 per month. Ninety-five per cent of the clinic patients were on full charity or part-pay basis as were 80 per cent of the emergency patients and 70 per cent of the inpatients.

At the same time, however (and here the taxpayers who support Robert B. Green found good reason to endorse business administration as opposed to old-time politics in public business), income from patients at Robert B. Green more than tripled! In the first five months of 1947, total income was $20,721.35. In the first five months of 1950 the income was $63,436.46.

How was that spectacular rise in income achieved?

Goldman Drury, hospital director, supplies the answer. Says he: "Our welfare department makes complete investigation into ability of every patient to pay. We give the patient every benefit of the doubt. You would be surprised how readily most patients will assume their obligations once they are informed that if they can pay even a little toward hospital care, they should pay that small amount."

Now, imbued with its bright new spirit, on the verge of an expansion program, Robert B. Green Hospital hopes that the dark days that have long plagued the institution are over.

Now that financial aid from the city, combined with the county funds, has resulted once again in the charity hospital's being a "going concern," the 40,000 men, women and children who find help and hope at Robert B. Green can thank the spirit of civic pride which reopened the hospital's doors.—ANGUS COCKRELL, *chairman, board of managers, and* GOLDMAN DRURY, *administrator, Robert B. Green Memorial Hospital, San Antonio, Tex.*

Kimble Culture Tubes No. 45048 and No. 45066 (with screw cap). Provided with sandblasted spot for marking.

Their long, useful life means low costs for you

Fewer culture tubes are broken than are retired from use because of etching and scratching. Tubes that stay clear provide the longest service—give you the lowest costs.

Kimble Culture Tubes are made of Kimble N51A glass—a borosilicate glass that has higher chemical durability than any other available.

In laboratories across the nation, tubes of Kimble N51A glass outserve others by wide margins. They especially resist alkaline and neutral solutions, including hot water and steam.

Make tests yourself. Use Kimble Culture Tubes side by side with any others available. Match them for clarity, for long life, any way you want. Your own records will show you how well these tubes serve . . . how much they can save.

You'll find, too, that Kimble Culture Tubes are the lowest-priced borosilicate tubes on the market. Your laboratory supply dealer will be glad to give you complete information about prices, types and sizes.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

Reader Opinion

Hospitalization of Negroes

Sirs:

I should like to express my appreciation and congratulations to you and your staff for the presentation of the honest and badly needed material on discriminatory practices in Northern hospitals. The articles in the June 1951 issue should go far toward impressing all those in any way responsible for hospital service with the obligations toward preserving democracy in health work.

At the Permanente Hospitals on the West Coast we have had, from the very beginning, a clear policy of nondiscrimination with patients and staff. There has been only one result: better service for patients.

There remains absolutely no justification for Jim Crowism in medical care, and your courageous series of articles will be an important step toward equal care for Negro patients in American hospitals.

E. Richard Weinerman, M.D.
Permanente Hospitals
Oakland, Calif.

Sirs:

This is just a note to congratulate you on the very fine series of articles in the June issue covering various aspects of hospitalization for Negroes. As I recall, you expressed an interest in doing something of this type more than two years ago, and I was happy to see such a concentrated effort at this time.

It has always been my sincere feeling that there is no more need for Negro hospitals than there is for any other specialized institution set up on the basis of race and color, and I am sure that these articles will have some effect on correcting the evils of such a deplorable situation. Also, it is my sincere hope that your magazine will continue its efforts in this direction.

C. C. Weil
Flint-Goodridge Hospital
New Orleans.

Sirs:

I want to express my gratitude to you for the very fine article on our nurse "walkout" in Charleston, W. Va.

Mother Mary Perpetua
St. Joseph's Convent
Wheeling, W. Va.

Sirs:

I want to congratulate The MODERN HOSPITAL for the courageous and long overdue discussion in your June issue of the problems of race prejudice in medicine in general and in hospitals in particular. Each time this subject is aired objectively, it brings us nearer to democratic justice.

I do not want to go into any protracted comment on the various points expressed. I do, however, think that Rev. Amos H. Carnegie strikes a note worthy of special consideration, inasmuch as he calls for initiative by the Negro people themselves and on an interracial basis. Under such a banner, there should be many millions of right-minded people, regardless of their color, who would be willing to lend a helping hand.

Isadore Rosenfield
New York City

Sirs:

I was particularly interested to read the various papers which appeared in the June issue dealing with the Evanston Community Hospital. I thought it was one of the finest issues that has been published in a long time. I do not know that the problem is at all settled in Evanston or in any other similar area throughout the country, but eventually we may find some solution which is not existing at the present time.

George K. Hendrix
Bureau of Hospitals
State Department of Public Health
Springfield, Ill.

Sirs:

Permit me to thank you for the excellent job you have done on the problem of hospital services for Negroes, a subject in which we have a special concern.

James A. Dombrowski
Southern Conference Educational Fund, Inc.
New Orleans

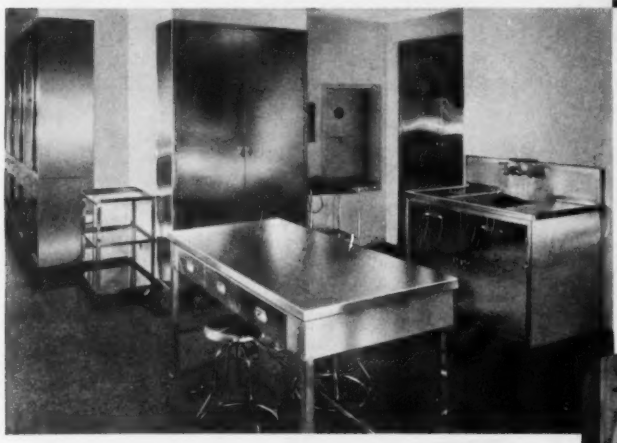
Sirs:

May I take this opportunity to congratulate you on the section on hospitalization for Negroes in the June issue? It has seemed to me that many of us associated with hospitals have not been articulate enough in taking a stand on this very important question. It has

Plan FOR "CENTRAL SUPPLY" EFFICIENCY

with Blickman-Built Cabinets and Casework

● Every hour of the twenty-four, demands are made on the central supply division for medical and surgical needs. Prompt service is vital and every article must be in place and in proper condition. To achieve this, equipment must be specifically designed to provide for efficient operation. Whenever possible, cabinets, casework, sinks and counters for the central supply room should be of stainless steel and of all-welded seamless construction. This assures maximum cleanliness, unusual durability and permanently-attractive appearance. Maintenance costs are low, periodic repainting is eliminated.



Above. STAINLESS STEEL GLOVE POWDERING BOX is shown here in use. Developed by Blickman designers, this Erie model provides a practical enclosed unit for powdering surgeon's gloves after washing.

Left. THE CENTRAL SUPPLY ROOM in St. Peter's Hospital, Albany, N.Y. functions efficiently with Blickman-Built stainless steel equipment. Note how recessed cabinets fit perfectly into wall spaces. Work table in foreground is designed so that nurses can work at both sides.

Below. STAINLESS STEEL COUNTERS with BUILT-IN SINKS—This is the receiving and cleaning section of St. Peter's Central Supply department. Stainless steel counters have sound-deadened work tops. Splash-back and work-top are integral. All corners, coves and intersections are fully rounded to facilitate cleaning.

The services of our engineering staff are at your disposal to help you plan an efficient, practical department designed to meet your specific requirements. Our experts will suggest the best possible use of available space, and submit plans for step-saving, time-saving layouts. Consult us—there is no obligation.

Send for our Bulletin No. 10-CBC —Illustrates and describes Blickman-Built cabinets and casework for every department of the hospital.

S. Blickman, Inc., 1508 Gregory Ave., Weehawken, N. J.

New England Branch: 845 Park Sq. Bldg., Boston 16, Mass.

You are welcome to our exhibit at the American Hospital Association Convention, Kiel Auditorium, St. Louis, Missouri, Booths No. 1414-16-18-20, September 17 to 20.

also seemed to me that much of the problem could be overcome if those concerned could get over their fears of the the consequences long enough to experiment with nonsegregation. I think all those who are interested in this subject owe you a vote of thanks for what you have done.

Mrs. Carol H. Cooley
Presbyterian Hospital
Chicago

Sirs:

Congratulations on printing the symposium on racial discrimination in hospitals. I hope the case studies presented will serve to convince more hospital administrators that segregation in hospitals is a social evil which must not be permitted to continue.

S. J. Axelrod, M.D.
University of Michigan
Ann Arbor, Mich.

Sirs:

Congratulations on this issue! The Negro section is sound and timely.

Michael M. Davis
Committee for the Nation's Health
Washington, D.C.

Sirs:

After having read the portfolio of articles on hospitalization for Negroes I would like to congratulate The MODERN HOSPITAL and its staff for presenting these articles to the hospital people. I'm sure they were not printed in vain, and I feel that they will serve to start many hospital people thinking about a problem that affects one-tenth of the population. I hope they will realize that a problem which affects the health activities of one-tenth of the population cannot help but affect or influence the health of the other nine-tenths.

Theodore D. Perkins
Freedman's Hospital
Washington, D.C.

Sirs:

Many thanks for the symposium on hospital care of Negroes which appears in the current issue. I believe this will provoke interest and discussion among the interested people throughout the United States.

Rev. Amos H. Carnegie
National Hospital Foundation, Inc.
Washington, D.C.

Sirs:

At the regular meeting of the board of directors of Davis Hosptal June 14, 1951, two Negro doctors were elected to the medical staff of the hospital for the first time in its history. This is the first time that Negro doctors have been given this opportunity in Pine Bluff. It is believed that Davis Hospital is the first and only hospital in Arkansas to admit Negro doctors to the staff.

R. C. Warren
Davis Hospital
Pine Bluff, Ark.

Sirs:

We have one Negro girl in our school of nursing, and I learned today that she is going to take the top honors in the school, receiving a handsome certificate and a hundred dollar gift. We also have one Negro doctor on the staff.

Alden B. Mills
Huntington Memorial Hospital
Pasadena, Calif.

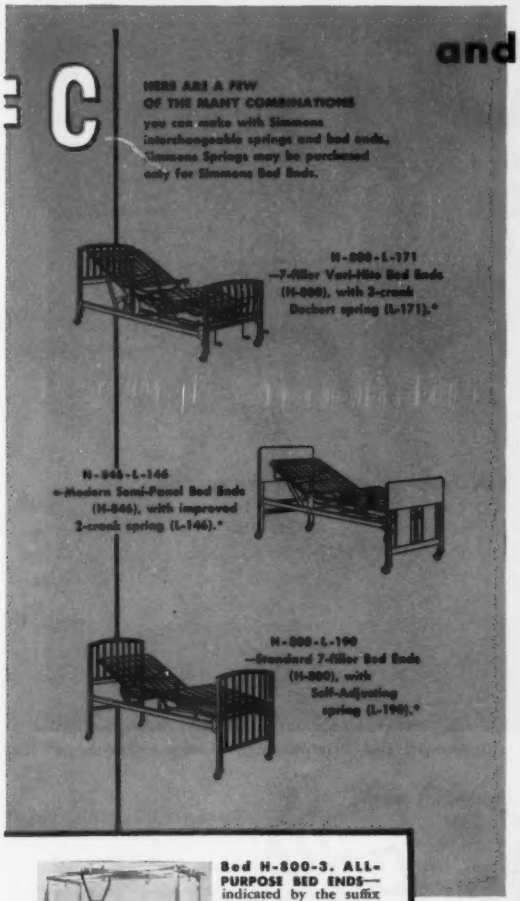
Sirs:

Cooperation between the races will make possible the meeting of the educational, health and welfare needs of both races within the pattern of segregation. When these needs have been met, we can't see segregation as anything more than a minor issue.

Anonymous
Greenville, S.C.

from SIMMONS complete line

makes it easier to pick the springs and Bed Ends you want!



Bed H-800-3. ALL-PURPOSE BED ENDS—indicated by the suffix (-3) added to the bed number. Have stainless steel baffle bars; built-in sockets for attaching demountable Balkan Frame H-16, Irrigation Rod H-69, and H-16E Shaped Fracture Bar. Have brackets for safety sides.

You'd Expect this of SIMMONS

Simmons, with the aid of down-to-earth suggestions from hospital administrators, doctors and nurses, has been busy working out a flexible system of interchangeable units—springs and bed ends—to help hospitals provide economically the many types of bed service they are expected to supply.

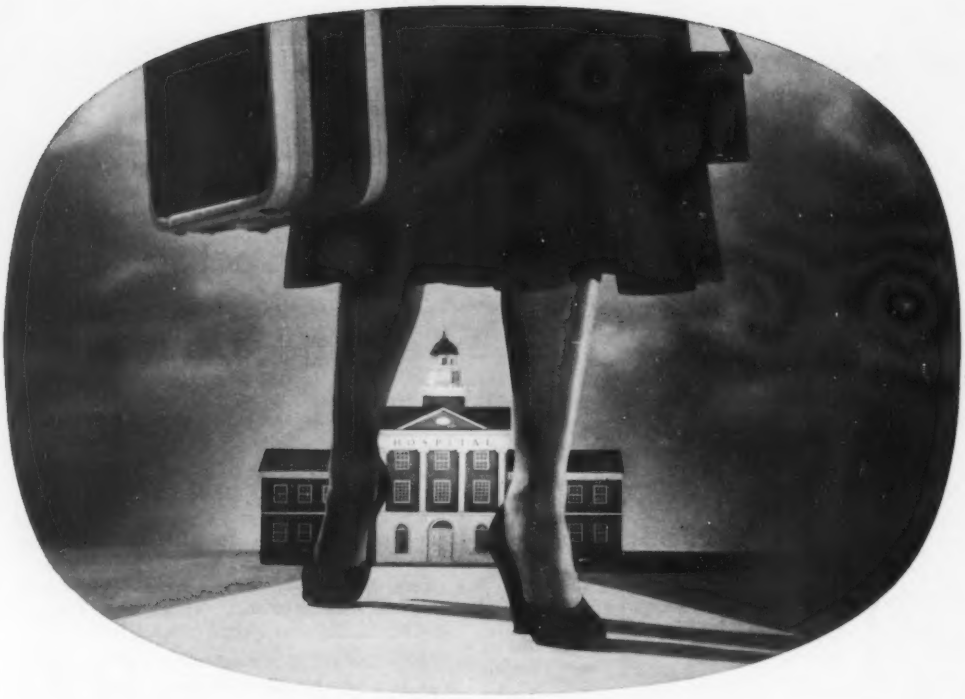
Now you can pick combinations of bed springs and ends which will enable you to provide all bed services with the minimum number of units—for surgery, obstetrics, fracture, convalescent, or special departments such as mental, heart and contagious. Your selection of ends is made easier because most Simmons bed ends are available plain, with brackets for safety sides, or with all-purpose features.

That's not all. You can choose from a wide range of easy-to-clean pastel colors or attractive wood grain finishes when you buy Simmons bed ends. Thus, your rooms and wards can be planned for color harmony as well as maximum service.

Simmons ABC System of Interchangeable Units as outlined here presents the basic idea. But to really understand the wide range of choice and the economy this system provides, see your hospital supply dealer, or visit a Simmons sales room.

SIMMONS COMPANY
HOSPITAL DIVISION

Chicago 54, Merchandise Mart
San Francisco 11, 295 Bay Street
New York 16, One Park Avenue
Atlanta 1, 353 Jones Ave., N. W.



The patient has recovered—but how about the *hospital*?

Patients discharged in the pink may leave a hospital in the red. Relying heavily on revenue from "third party" agencies, many a hospital suffers today from budget deficiency.

Unless it can *prove* costs for services rendered, a hospital may be short-changed by inequitable payment rates.

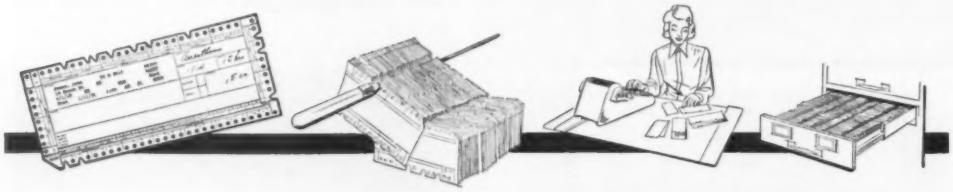
Guesswork doesn't work. A hospital has to put its cards on the table.

When the cards are McBee Keysort Charge Tickets, that's easy. A charge ticket for each patient identifies each unit of service and enables a hospital to get complete data needed to substantiate cost claims.

With existing personnel, without costly installations, McBee Keysort Charge Tickets and machines can provide any hospital with complete cost-control more economically than with any other method.

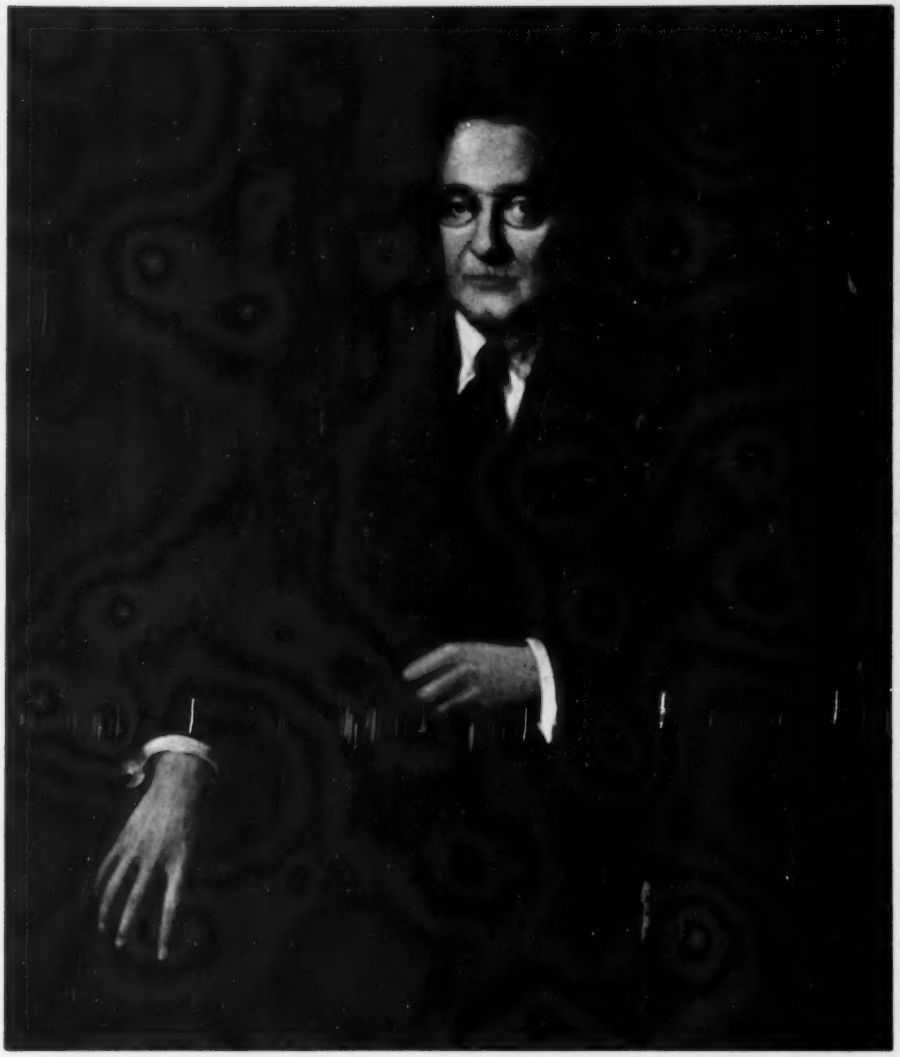
When notched, the pre-coded holes along the edges of each Keysort Charge Ticket make it easy to *collect* the facts on each patient . . . *classify* them . . . *file* them . . . *find* them . . . *use* them . . . quickly and accurately.

Get the full story from the McBee representative near you. Or write us.



THE McBEE COMPANY

Sole Manufacturer of Keysort—The Marginally Punched Card
295 Madison Avenue, New York 17, N. Y. *Offices in principal cities.*



FROM A PAINTING BY WILLIAM T. THOMPSON

COURTESY, JEFFERSON MEDICAL COLLEGE

John Chalmers Da Costa

1863–1933

John Da Costa was born in Washington, D.C., November 15, 1863. He graduated from the University of Pennsylvania in 1882 and from Jefferson Medical College in 1885. For about 45 years, Dr. Da Costa was a member of the faculty of Jefferson Medical College. The first Samuel D. Gross Professor of Surgery, he occupied this chair until his death. He was consulting surgeon to the Philadelphia Hospital, St. Joseph's Hospital and Misericordia Hospital, and served as surgeon to the Pension Fund of the Philadelphia Fire Department. His international reputation as a teacher and surgeon brought him many honors. Under the auspices of the Philadelphia County Medical Society, Da Costa Day was inaugurated in 1930, and the John Chalmers Da Costa Foundation was established to further graduate teaching.

less tissue reaction

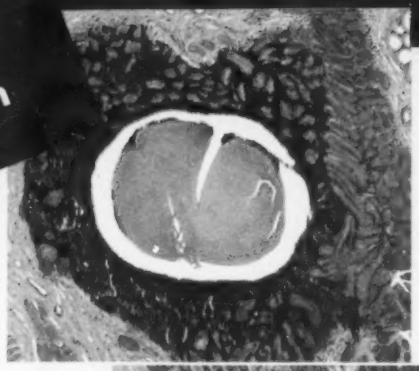


Fig. 1

with finer-gauged surgical gut

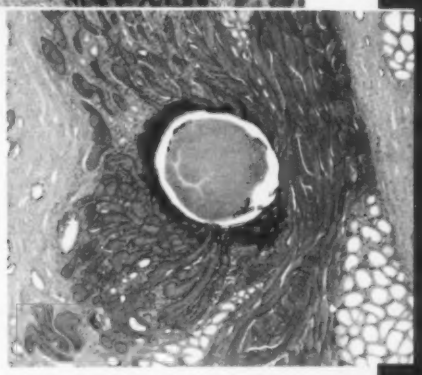


Fig. 2

These histologic sections strikingly illustrate the advantages of finer-gauged

ETHICON®

Surgical Gut:

Less tissue trauma.
Decreased foreign body reaction.
Fewer complications.
Lowered tendency toward infection.
Better apposition of wound edges.

Composite sections of surgical gut embedded in abdominal wall of rabbit and removed on 7th day. In Figure 1, size 2 Medium Chromic Surgical Gut caused extensive leucocytic infiltration and inflammatory exudate. In Figure 2, size 00 Medium Chromic Surgical Gut caused far less tissue reaction, as seen by the minimal leucocytic infiltration and absence of inflammatory exudate. (Clear zones surrounding gut are artifacts caused by fixation shrinkage.)

Finer Sutures for Finer Surgery

Most strands of ETHICON surgical gut meet the USP tensile strength requirements for the next larger size. ETHICON Tru-Gauging and Tru-Chromicizing processes give remarkable uniformity of gauge, strength and chrome distribution.

The booklet "Surgical Experience with Respect to the Use of Finer Size Sutures" is now available. May we send you a copy?

ETHICON SUTURE LABORATORIES
INCORPORATED
Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil; Sydney, Australia; Edinburgh, Scotland.

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—28th Edition

DUNHAM

vari-vac differential heating

Cuts fuel costs up to 40%

Norman F. Beatty Memorial Hospital, Westville, Ind. Architect: Boyd E. Phelps, Inc., Michigan City, Ind. Heating Contractor: Robert Gordon Co., Chicago, Ill.

St. Thomas High School, Houston, Tex. Architect & Consulting Engineer: Maurice J. Sullivan, Houston, Tex.

provides precision temperature control for every type–every size–building

Substantial Savings in Fuel Costs are assured with Dunham Vari-Vac* Differential Heating Systems. That's because outside weather and inside temperatures automatically control steam consumption. No more steam is ever used than is necessary.

Dunham Vari-Vac economizes with a "continuous" flow of sub-atmospheric steam at variable pressures and temperatures. In severe weather, Vari-Vac uses steam as "hot" as 218° F. In mild weather, smaller quantities of steam as "cool" as 135° F. are expanded to meet comfort needs.

Sized to Suit Your Needs . . . in New or Existing Buildings. Seven different systems are available, depending on the degree of control you desire. Whichever system you choose—whether a simple, manually operated Basic Job or a fully automatic Supreme Installation—you're sure to enjoy maximum fuel economy and comfort . . . regardless of the size, type, age or location of your building.

**Variable Vacuum*

Instantaneous response to outside weather changes.

Convenience of centralized operation.

Automatic Compensation for heat loss.

Heat supply and demand perfectly balanced.

Send for Free Booklet 2101-19. Tells all you will need know about this amazing system—how it operates, how it may be fitted exactly to your needs. Write for your copy.

C. A. DUNHAM COMPANY

400 W. Madison Street, Chicago 6, Illinois

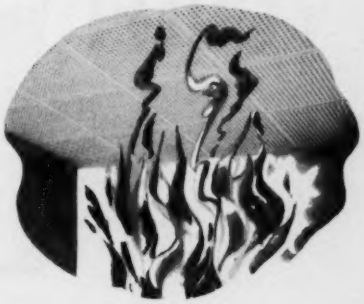
In Canada: C. A. Dunham Co., Ltd., Toronto • *In England:* C. A. Dunham Co., Ltd., London

Fin-Vector Radiation • Baseboard Radiation • Convector Radiation • Vacuum Pumps Condensation Pumps • Horizontal and Vertical Discharge Heaters • Traps • Valves

QUESTIONS about acoustical materials . . .

Q Can acoustical materials withstand fire?

A Many of them can. Armstrong's Travertone (mineral wool) and Armstrong's Arrestone (mineral wool and steel), are rated incombustible by the U. S. Bureau of Standards. Classed as "slow-burning" are Corkoustic, made of natural cork, and wood fiber materials like Cushiontone (when treated with fire-resistant paint to meet Federal Specifications).

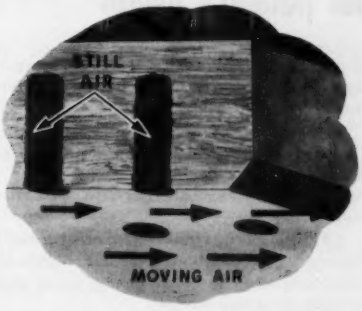


Q Is moisture harmful?

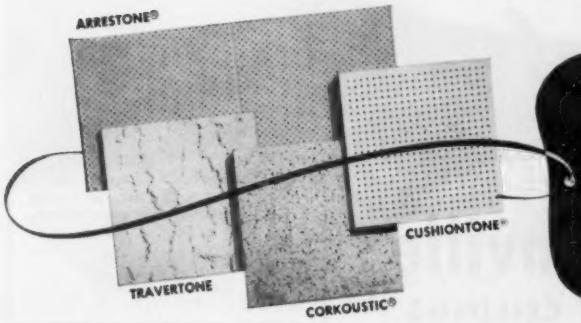
A Normal humidity in the air will not harm most acoustical materials. Extreme dampness—like that found in kitchens and swimming pools—can cause warping or decay. The material recommended for such areas is Armstrong's Corkoustic. Its cork composition makes it highly moisture resistant.

Q Do the openings in acoustical materials collect dust?

A No, the perforations of Armstrong's Cushiontone, for example, or the fissures of Armstrong's Travertone do not readily collect dust and dirt. That's because these openings contain still air. Any dust that moving air may deposit on the face of the material is easily removed by brushing or vacuum cleaning.



FREE BOOKLET, "How to Select an Acoustical Material," answers many questions about sound conditioning. Write to Armstrong Cork Company, 5708 Stevens St., Lancaster, Pa.

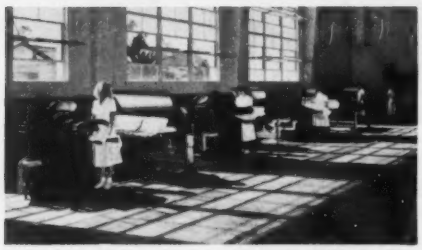


ARMSTRONG'S ACOUSTICAL MATERIALS

At Cedars of Lebanon Hospital, NOTRUX Extractor (left), and CASCADE Automatic Unloading Washers with Full-Automatic Controls, reduce handling of work in washroom to an absolute minimum.

"AMERICAN" Equipped Laundry Department

SAVES...TIME...LABOR...COSTS



Staff uniforms and personal apparel are quickly ironed with a high quality finish on these 4 AMERICAN Press Units.

TRUMATIC Folder at delivery end of SYLON Flatwork Ironer automatically quarterfolds large linens lengthwise, requiring only one receiving operator to cross-fold and stack work.

at Cedars of Lebanon Hospital, LOS ANGELES

In keeping with their fine reputation for the best in all hospital facilities, Cedars of Lebanon Hospital decided to install a new AMERICAN-equipped laundry department.

Our Laundry Advisor made a complete analysis of the Hospital's clean linen needs and recommended AMERICAN automatic equipment to assure best quality work and most efficient operation for years to come. Since installation of the new laundry, management of the Hospital reports these *outstanding savings:*

- **Saved labor of 4 operators.**
- **Saved 42 hours a week laundry operating time.**
- **Saved $7,200 a year in operating costs.**
- **Saved 50% on washroom supplies.**

You too can make remarkable savings by installation of AMERICAN high-production, automatic equipment. Consult our Laundry Advisor, he will make a survey to determine the best method of handling your clean linen problem. His services are offered *without any cost or obligation whatever.* **WRITE TODAY** . . . for our Laundry Advisor to call at your convenience.

REMEMBER . . . Every Department of Your Hospital Depends on the Laundry.

The AMERICAN LAUNDRY MACHINERY CO.

CINCINNATI 12, OHIO

Quality Soaps Are Part of Fine Hospital Service

PALMOLIVE SOAP
Popular with Millions!

Palmolive, requested, enjoyed, made popular by millions, meets highest hospital standards for purity. Provides abundant mild lather.

CASHMERE BOUQUET
A Favorite Luxury Soap!

Cashmere Bouquet, the aristocrat of fine toilet soaps, is a big favorite in private pavilions, because women like the delicate perfume and creamy lather of this hard-milled luxury soap.

COLGATE'S FLOATING
Economical!

Colgate's Floating Soap is made especially for hospital use—meeting the most exacting requirements for purity, mildness and *economy*.

To Please Patients And Provide Quality, Too... Superintendents And Purchasing Agents Choose Colgate-Palmolive-Peet Toilet Soaps

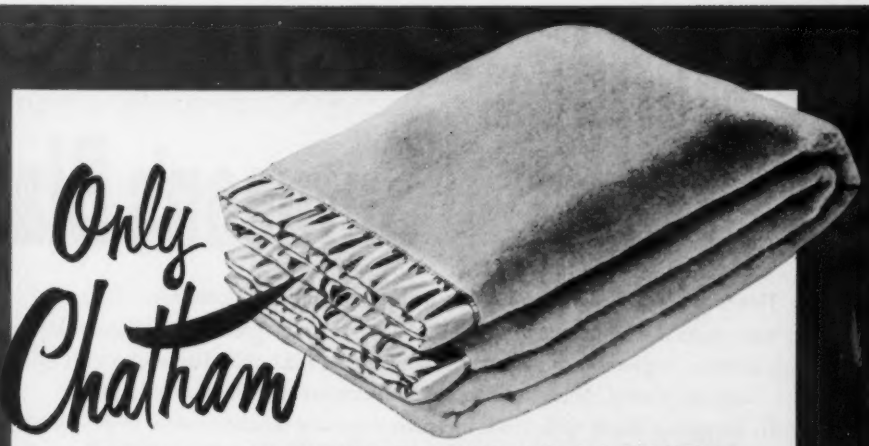
Hospital superintendents know the touch of prestige that these famous and familiar Colgate-Palmolive-Peet soaps give private rooms and pavilions.

Experienced purchasing agents choose long-lasting Colgate-Palmolive-Peet soaps because they're economical in use—and all of them meet the most rigid requirements for purity and mildness.

Free New 1951 Handy Soap Buying Guide. Tells you the right soap for every purpose! See your C.P.P. representative, or write now to our Industrial Department.

Colgate-Palmolive-Peet Company

JERSEY CITY 2, N. J. · ATLANTA 3, GA. · CHICAGO 11, ILL.
KANSAS CITY 3, KANS. · BERKELEY 10, CALIF.



Only Chatham ...OFFERS A COMPLETE LINE OF BLANKETS

Chatham, one of the world's largest manufacturers of woolen blankets, has employed over 70 years of experience to create a line of blankets particulary designed for institutional service. These blankets are more closely woven than ordinary household blankets and are specially finished with a low, tight, institution-type nap. That's why you'll find Chatham's label on blankets in the best hotels and hospitals from coast to coast.

SPECIALLY CONSTRUCTED FOR HOTELS AND HOSPITALS

100% Wool

No. 300. Closely woven of tightly spun, high tensile strength all-wool yarns, this blanket is designed to provide extra years of satisfactory service.

70% Wool

No. 400. Fine quality wool tightly spun around a sturdy cotton core forms the all-wool nap. Extra closely woven on a selected cotton warp for maximum warmth and strength.

50% Wool

No. 900. For "warmth without weight" and really rugged strength. Although this blanket is 50% wool and 50% cotton by weight, its nap is over 85% wool.

25% Wool

No. 500. To the best of our knowledge, this is the best constructed 25% wool—75% cotton blanket on the market. Its nap is more than 45% wool.

5% Wool

No. 600. Core-yarn filled on an all-cotton warp for maximum strength, this blanket is the most closely woven blanket of its kind on the market.

All Cotton

No. 700. The utmost in strength, warmth, and service in an all-cotton blanket. Especially designed for use in hospital operating sections.

Sold only through selected institutional distributors

chatham makes good blankets

Send for free swatches and latest price list.

CHATHAM blankets

Chatham Manufacturing Co., Mills—Elkin, N. C. • Institution Blanket Dept.—57 Worth St., N. Y. 13, N. Y.

The World's Finest Surgeon's Blade

This is the A.S.R. Surgeon's Blade with the ultra-keen 'Command Edge.' It represents the highest achievement of fifty years of precision craftsmanship . . . a blade so true, so precise, so perfectly balanced that it literally becomes a part of the surgeon's hand. Many leading surgeons report that the keen, durable A.S.R. Surgeon's Blade withstands incisions normally requiring *three* or *four* blades . . . saving many precious minutes of operating time.

1. A.S.R. Surgeon's Blades get double protection against moisture. They are first wrapped in heavy wax paper

2. . . . and are then hermetically sealed in aluminum foil. Can be stored for years and still retain matchless uniformity and keenness.

A. S. R.
Double Edge Razor Blades
(for hospital use)

Same superior steel—same technical excellence as A.S.R. Surgeon's Blades.
Fit any standard double edge razor . . . Convenient packs of 100.

A. S. R.
Sanitary Utility Protector
Has 8 practical uses, among them:

- Bedpan Cover
- Treatment Tray Cover
- Urinal Cover
- Bedside Nursing Bag
- Douche Tray Cover
- Glove Case for Autoclaving

A.S.R. SURGEON'S BLADES with the 'Command Edge'

fit all A.S.R. and all standard surgical blade handles

PRECISION ASR PRODUCTS

A.S.R. HOSPITAL DIVISION, AMERICAN SAFETY RAZOR CORPORATION, BROOKLYN 1, NEW YORK

Will you make this costly mistake when you build your new hospital?

IN THE INTEREST OF ECONOMY, the gentlemen above are voting *not* to install individual room temperature control in their new hospital.

Will this prove to be *false* economy—a really costly mistake? Very likely!

As most hospital administrators know—it is becoming more and more routine in medical practice to give each patient the exact room temperature he needs to accelerate his recovery—whether it's 65° or 85°. And this "prescription" can be filled *only* with individual room temperature controls. No other system can maintain different temperatures in different rooms. No other system can compensate for the varying effects of wind, sun, open windows and number of room occupants.

Since that is true, it's just smart business to install individual room temperature controls *when your hospital is being built.* Doing it later, as a modernization project, is sure to cost substantially more money.

So why not get the complete facts and figures on Honeywell Controls for your your new hospital? Honeywell—first in controls—offers many important features you'll want, including the only thermostat specially designed for a hospital's special needs. For quick service, just call your local Honeywell office. Or mail the coupon today!

MINNEAPOLIS
Honeywell
First in Controls

MINNEAPOLIS-HONEYWELL REGULATOR CO., Hospital Controls
351 E. Ohio St., Chicago 11, Ill., Dept. MH-8-131

Gentlemen:

Please send me literature and full details on individual room temperature control for hospitals.

Name_____ Title_____

Hospital Name_____ Address_____

City_____ Zone____ State_____

CONSTRUCTION AND BUILDING EQUIPMENT

Welding Equipment

Flood Lighting

Freight Elevators

Motors and Control

Wiring Devices

Passenger Elevators

POWER DISTRIBUTION EQUIPMENT

Panelboards

Power Centers

AB-I Breakers

Bus Duct

Load Centers

Meters and Instruments

HEATING AND VENTILATING EQUIPMENT

Air Conditioning Equipment

Forced Fans

Precipitron*

Unitaires

Fans

Stokers

*Reg. U.S. Trademark

BE SURE... IF IT'S Westinghouse

One reliable source for Everything Electrical... to distribute, control and utilize electric power

Badly needed expansion of both government and private hospitals is now bringing construction programs to an all-time peak.

For this type of construction, as well as all other commercial and industrial buildings, Westinghouse offers architects and contractors a unique advantage. *Everything electrical*—from distribution and control apparatus to highly specialized x-ray and lighting equipment—can be obtained through one reliable source.

By centralizing responsibility with Westinghouse for power distribution equipment, construction and building equipment, heating and ventilating equipment and lighting units, you gain important advantages:

1. SPECIALIZED ENGINEERING . . . to assist in selecting and applying equipment for maximum efficiency.

2. SIMPLIFIED ORDERING . . . by providing a focal point of contact for all buying and specification data.

3. SPEEDIER INSTALLATION . . . by centralizing responsibility for delivery and installation.

4. BETTER, MORE RELIABLE SERVICE . . . through the co-ordinated design and construction of Westinghouse equipment, plus broad experience in applying it for all types of buildings. Westinghouse also offers unmatched electrical maintenance service, through its nationwide chain of Renewal Parts Warehouses and Manufacturing and Repair Shops.

Call your nearest Westinghouse District Office or Distributor for full information on this co-ordinated service. When there's CONSTRUCTION AHEAD requiring electrical equipment of any kind . . . you can be *sure* if it's Westinghouse. J-94782-C

An excellent Aid to Distribution System Planning

Fact-filled pages and color diagrams completely explain the 11 basic systems used in industry today. This booklet will provide a specific answer to your power distribution problems.

LAMPS AND LIGHTING EQUIPMENT

Lighting Equipment

Sterilamps

Fluorescent Luminaires

Sun Lamps

Heat Lamps

Light Bulbs

CLINICAL AND SERVICE EQUIPMENT

X-Ray Equipment

Electric Ranges

Refrigerators

Laundry Equipment

Water Heaters

Water Coolers

Westinghouse

PLANTS IN 25 CITIES . . . OFFICES EVERYWHERE

WORLD-WIDE DISTRIBUTION OF ACTHAR*

and Other Pharmaceuticals of The Armour Laboratories

ARGENTINA
John Wyeth Laboratories S. A.
Paseo Colón 1102
Buenos Aires, Argentina

AUSTRALIA
The Sigma Company Ltd.
562-566 Little Bourke Street
Melbourne, C.1, Australia

BELGIUM

BELGIAN CONGO

HOLLAND

LUXEMBOURG
Messrs. Etablissements A. Couvreur
78-80 Rue Gallait
Brussels, Belgium

BOLIVIA
S. A. C. I. (Sucs. de S. F. Bedoya)
Casilla 346
La Paz, Bolivia

BRAZIL
Industrias Farmacêuticas Fontoura-Wyeth S. A.
Rua Caetano Pinto 129
Sao Paulo, Brazil

CANADA
The Armour Laboratories
Laurentian Agencies, Reg'd.
429 St. Jean Baptiste St.
Montreal, Quebec

CHILE
Sr. Roger Couly L.
Casilla 1459
Santiago, Chile

COLOMBIA
Laboratorios Román, S. A.
Apartado Aéreo 150
Cartagena, Colombia

COSTA RICA
Lic. Agustín Membreño Palma
Apartado 1749
San José, Costa Rica

CUBA
Droguería Alvarez Fuentes
Avellaneda No. 225
Camagüey, Cuba

Droguería Cooperative de Cuba
Apartado No. 222
Havana, Cuba

Droguería La Cosmopolita
Apartado 55
Cienfuegos, Cuba

Droguería Danhauser
Neptuno 516
Havana, Cuba

Droguería de Johnson
Apartado 750
Havana, Cuba

Droguería Mestre y Espinosa
Apartado 65
Santiago de Cuba, Cuba

*The Armour Laboratories Brand of Adrenocorticotropic Hormone (A.C.T.H.)

CUBA (continued)

Droguería Sarrá
Apartado 50
Havana, Cuba

Droguería Taquechel
P.O. Box 103
Havana, Cuba

Droguería Berenguer
Apartado 458
Santiago de Cuba, Cuba

Droguería Amiguet
San Lázaro 902
Havana, Cuba

DENMARK
SWEDEN

Messrs. Hunnerup Hansen Wiik & Co. A/S.
Dampfaergevej 23
Copenhagen, Denmark

DOMINICAN REPUBLIC

Jaime Méndez Sucs., C. por A.
Apartado 27
Ciudad Trujillo, Dominican Republic

EAST AFRICA

Messrs. Dalgetty & Company Ltd.
Nairobi, East Africa

ECUADOR

Sociedad Comercial Anglo-Ecuatoriana, Ltda.
Casilla 410
Guayaquil, Ecuador

EGYPT

Messrs. Imperial Chemical Industries (Egypt) S.A.
P. O. Bag
Cairo, Egypt

EIRE

Messrs. May, Roberts (Ireland) Ltd.
Grand Canal Quay
Dublin C. 6, Ireland

EL SALVADOR

Félix Cristiani & Cía
Farmacia Santa Lucía
San Salvador, El Salvador

ENGLAND

The Armour Laboratories
Lindsey Street—Smithfield
London, E. C. 1, England

FINLAND

Messrs. Havulinna Oy.
P. O. Box 468
Helsinki, Finland

FRANCE

Messrs. Reyns & Maurel
15 rue du Louvre
Paris, France

GERMANY

Messrs. Tietgens & Robertson
Messberghof
Hamburg 1, Germany

GREECE

Messrs. Danon & Danon
12 Kolocotroni Street
Athens, Greece

GUATEMALA

Julio R. Matheu
Apartado 108
Guatemala City, Guatemala

HAITI

Joseph Nadal & Cía.
Port-au-Prince, Haiti

HONDURAS

Honduras Radio & Machine Co.
(Luis F. Lazarus Co.)
Tegucigalpa, Honduras

HONG KONG

Imperial Chemical Industries (China) Ltd.
P. O. Box 107
Hong Kong

INDIA

Messrs. Jubilee Pharmaceuticals Agency Ltd.
14 Pollock Street
Calcutta 1, India

IRAN

Etablissements Docteur Tebbi
Siege Central
Nasser Khosrow
Saraye Rowchan
Teheran, Iran

IRAQ

Messrs. Ellis Ezra Sion & Co.
57-233 Ghazali Street
Baghdad, Iraq

ISRAEL

Messrs. D. Liebermann & Co.
"Pharmed"
13 Petah-Tiqva Road
Tel Aviv, Israel

ITALY

Messrs. Farmaceutica Internazionale s.r.l.
Palazzo Nuovo Borsa 3
Piano No. 60
Genova, Italy

JAPAN

Industries Export Corporation
Tokyo, Japan

MALAYA

Messrs. Imperial Chemical Industries (Malaya) Ltd.
Singapore

MALTA

Messrs. Fabri & Tonna
43 Lascaris Wharf
Valletta, Malta

MEXICO

Serral S. A.
Fray Servando Teresa de Mier No. 120
México, D. F., México

NETHERLAND WEST INDIES

Aruba Mercantile Company
P. O. Box 106
Oranjestad, Aruba
Netherland West Indies

NEW ZEALAND

Messrs. Oral Supplies Ltd.
Auckland, New Zealand

NICARAGUA

Constantino Pereira & Cía., Ltda.
Managua, Nicaragua

NORWAY

Messrs. Tecknisk-Kjemisk A/S WA-MO
Kong Oscarsgt 23
Bergen, Norway

PANAMA

José Cabassa
Apartado 148
Panamá, R. P.

PARAGUAY

Vicente Scavone & Cía.
C. Correo 427
Asunción, Paraguay

PERU

Duncan, Fox & Co., Ltd.
Apartado 2717
Lima, Peru

PHILIPPINE ISLANDS

Mr. Miguel L. Lorza
P. O. Box 943
Manila, Philippine Republic

PORTUGAL

Messrs. Alves & Co. (Irmaos)
Rua dos Correeiros 41-2nd
Lisbon, Portugal

PUERTO RICO

Luis Garratón, Inc.
P. O. Box 2984
San Juan, Puerto Rico

SIAM

Messrs. Wat Som-Chin Dispensary
93-95 Rama IV Road
Bangkok, Siam

SOUTH AFRICA

Messrs. Petersen Ltd.
3/22 Barrack Street
Cape Town, South Africa

SPAIN

Messrs. Productos de Carne
Apartado 548
Barcelona, Spain

SWITZERLAND

Messrs. Helvepharm, G.m.b.H.
Missionsstr 15
Basel, Switzerland

SYRIA

Messrs. Bercoff & Fils
Rue Al-Moutran
B. P. 119
Beyrouth, Lebanon, Syria

URUGUAY

Vicente F. Costa
Juncal 1488
Montevideo, Uruguay

VENEZUELA

Higia, C. A.
Apartado 768
Caracas, Venezuela

THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS, U.S.A.

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

CHICAGO 11, ILLINOIS • NEW YORK 11, NEW YORK • DALLAS 4, TEXAS • SAN FRANCISCO 18, CALIFORNIA

THE IDEAL AMINO ACID PRODUCT FOR TUBE FEEDING

the Stuart amino acids

(SOLUBLE BEAD FORM)

Can be used as the sole source of amino acids to maintain nitrogen balance. Contains all the amino acids (and only amino acids)

Completely soluble—no clogging

High solubility permits massive dosage with smaller amounts of liquid. 5 grams (approximately one tablespoonful) is completely soluble in 1 ounce of water

No digestion necessary —Immediately available for absorption

Easy to prepare for patient —Readily soluble

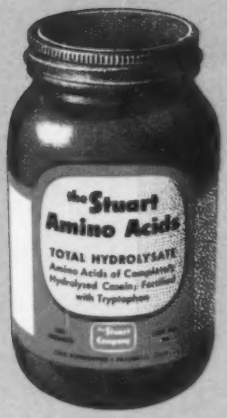
PHARMACEUTICALS the Stuart Company DEPENDABLE ETHICAL

THE STUART AMINO ACIDS IS AVAILABLE AT ALL DRUG WHOLESALERS AND PHARMACIES

The First Complete Amino Acids
Product For Oral Use

the Stuart Amino Acids

(SOLUBLE BEAD FORM)

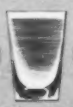


The Stuart Amino Acids contains *all* the amino acids (and *only* amino acids) in correct ratio to maintain nitrogen balance and can be used as a supplement or the sole source of amino acids.

Complete solubility allows massive dosage. As much as 5 grams of the Stuart Amino Acids is soluble in 1 ounce of water or other liquids. 6 ounce bottle available at all pharmacies.

COMPLETELY AND READILY SOLUBLE

BLAND, SLIGHTLY BOUILLON TASTE MEANS HIGH PATIENT ACCEPTANCE

CAN BE TAKEN IN  **LARGE OR SMALL**  **AMOUNTS OF LIQUIDS,**

 **HOT OR COLD**  **WATER, SOUPS** 

TOMATO OR  **VEGETABLE JUICES,**  **CARBONATED BEVERAGES**

PHARMACEUTICALS · the Stuart Company · DEPENDABLE ETHICAL

For a demonstration of bland taste and complete solubility, write the Stuart Company, 234 East Colorado Street, Pasadena, California

HOSPITALS

can save time and money with

PHOTOSTAT

REG. U. S. PAT. OFF.

Photographic Copying Equipment

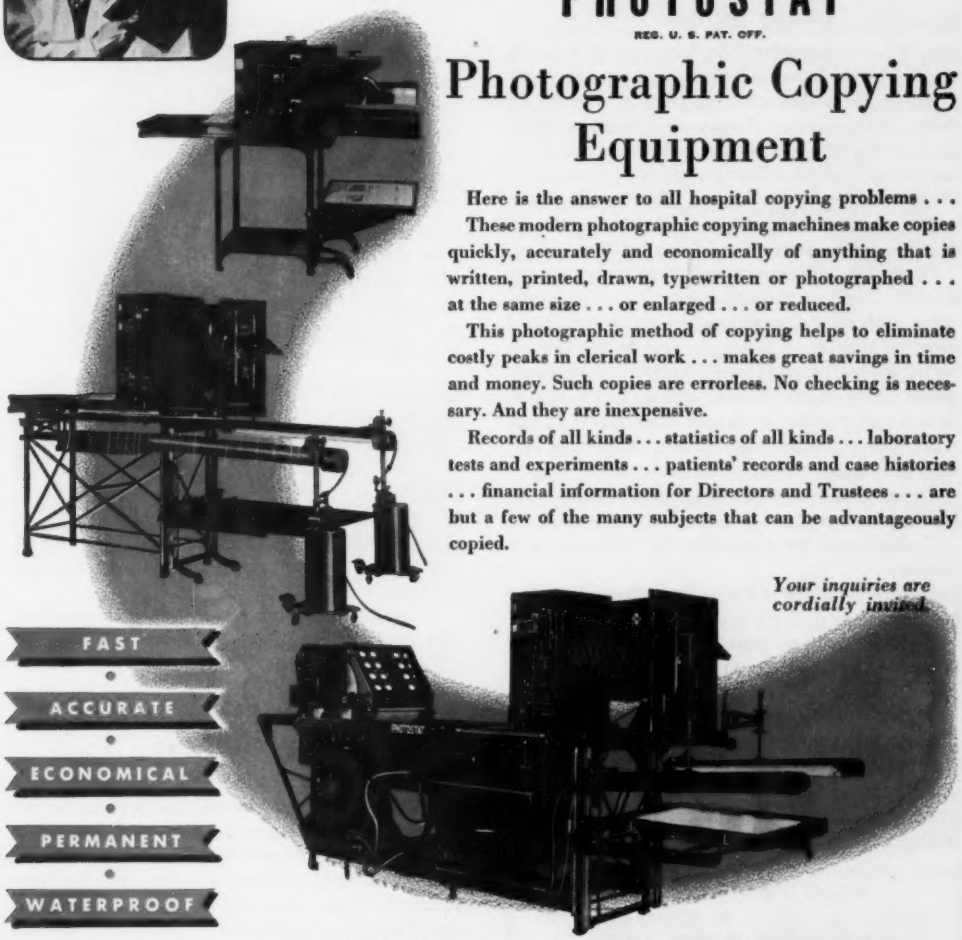
Here is the answer to all hospital copying problems . . .

These modern photographic copying machines make copies quickly, accurately and economically of anything that is written, printed, drawn, typewritten or photographed . . . at the same size . . . or enlarged . . . or reduced.

This photographic method of copying helps to eliminate costly peaks in clerical work . . . makes great savings in time and money. Such copies are errorless. No checking is necessary. And they are inexpensive.

Records of all kinds . . . statistics of all kinds . . . laboratory tests and experiments . . . patients' records and case histories . . . financial information for Directors and Trustees . . . are but a few of the many subjects that can be advantageously copied.

Your inquiries are cordially invited.



FAST

•

ACCURATE

•

ECONOMICAL

•

PERMANENT

•

WATERPROOF

PHOTOSTAT CORPORATION

303 STATE STREET, ROCHESTER 14, NEW YORK

Service Offices in All Principal Cities

PHOTOSTAT is the trade-mark of PHOTOSTAT CORPORATION

Published by Clay-Adams Co., Inc.
141 EAST 25TH STREET,
NEW YORK 10, N. Y.
Showrooms also at 308 W. Washington St., Chicago 6, Ill.

Clay-Adams

Sedimentation Rates Valuable Adjunct in Diagnosis

Blood sedimentation tests are well-established laboratory procedures. As long ago as 1797, it was first noted that inflammatory processes increased the sedimentation rate of red blood cells. Explanations of this phenomenon vary, but there is little doubt that sedimentation rates can provide an excellent clue to the presence or absence of an inflammatory process. In some cases, the sedimentation rate is an accurate indication of the severity of the infection.

Generally, changes in sedimentation rate are a more sensitive indicator than body temperature, and many investigators have published detailed studies on these changes in various infectious conditions. The sedimentation rate is a particularly valuable indicator in tuberculosis, pelvic inflammatory disease, rheumatic fever, infectious arthritis, pneumonia, Hodgkin's disease and acute coronary thrombosis.

In general practice, the sedimentation rate has three important practical applications:

1—Indicates the presence of inflammatory process

2—Indicates the activity and progress of the condition

3—Aids in differential diagnosis. Studies have shown characteristic sedimentation rates for conditions whose initial symptoms are nonspecific.

Methods now available for determining sedimentation rates include macromethods, the most popular of these being Wintrobe, Westergren, Cutler and Linzenmeier, in which blood is withdrawn by venipuncture. In the Landau-Adams, which is a micromethod, only a drop or two of blood, which may be taken from the fingertip, is required. The latter is particularly suited for corpulent adults and children, where it is often difficult to do a venipuncture, or in any case where repeated blood withdrawals are contemplated.

Landau-Adams Microsedimentation Apparatus

A leaflet describing the various apparatus and methods for blood sedimentation is available on request.

SPECIAL LITERATURE AVAILABLE

Detailed descriptions on the following may be obtained from Clay-Adams on request by number:

Polyethylene Tubing	Form No. 447B
Blood Sedimentation Apparatus	Form No. 448
Gastrectomy Tube	Form No. 119/104
GOLD SEAL Slides and Cover Glasses Price List	Form No. 42PL

Experimental Procedures Utilize Polyethylene

Biologists attending the recent Cleveland meeting of the Federation of American Societies for Experimental Biology showed great interest in the adaptability of polyethylene tubing to various experimental procedures in physiology and surgery. Clay-Adams animal-tested Polyethylene Tubing is available in 23 sizes ranging from inside diameters of .011″ to .500″—small enough to cannulize a vein in a bat's wing, or large enough to replace a dog's aorta. Because it is free from tissue reaction, Clay-Adams polyethylene tubing may be left in the body without side reactions.

Newsletter

FOR THE MEDICAL AND BIOLOGICAL SCIENCES
Number 5 of a Series

MICRO SLIDES AND COVER GLASSES:

Special Glass, Precision Methods Insure Gold Seal Quality

Careful, accurate and uniform manufacturing processes make Clay-Adams GOLD SEAL Slides and Cover Glasses leaders in their fields.

GOLD SEAL Microscope Cover Glasses are made of special hand-blown glass of extreme hardness. The glass blanks from which the cover glasses are cut come in large, thin sheets of varying thickness. Trained technicians carefully gauge each section of the glass and mark off pieces of uniform thickness. The glass sheets are also inspected for irregularities such as bubbles, striae and cracks. A surprisingly large

UNRETOUCHED PHOTO *shows effect of time on an ordinary (L.) and a* GOLD SEAL *cover glass.*

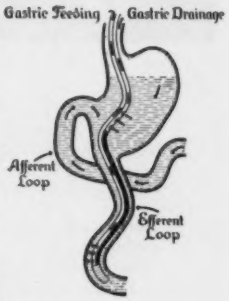
percentage of glass per pound is rejected as unfit. This careful processing guarantees that, within a given thickness, the user gets more cover glasses per ounce.

GOLD SEAL Micro Slides are made to similar rigid specifications. For years they have been the standard for comparison among the country's leading histologists. Each slide is carefully inspected to detect all defects and imperfections. Edges are carefully ground and polished.

Even after years of use, GOLD SEAL Slides and Cover Glasses will not corrode or fog (see illustration).

GOLD SEAL Slides and Cover Glasses are available in various sizes of squares, rectangles and circles.

Simple Gastrectomy Tube for Feeding and Drainage



The Einhorn Simultaneous Bilumen Gastrectomy Tube affords a simple method for simultaneous or independent jejunal feeding or drainage and gastric drainage. The tube is simple to insert or withdraw, since it is bucketless. It is introduced through the nose prior to the operation, and slipped into the jejunum after anastomosis.

The Einhorn Gastrectomy Tube is 48″ long bisected by a center wall to give a double semicircular lumen. Each lumen can be used separately since they have separate openings at both ends. The shorter lumen opens into the stomach 14½″ above the end of the tube. The tip of the tube is weighted for smooth and easy passage.

HERE IS A PARTIAL LIST OF OUR PRODUCTS

- Adams Centrifuges
- Uterine Cancer Detection Kits
- Blood Analysis Instruments
- GOLD SEAL Slides & Cover Glasses
- Supplies for Microscopy
- Dissecting Kits
- Surgical & Dissecting Instruments
- Surgical Rubber Goods
- Anatomical Charts & Atlases
- Clinical Laboratory Supplies
- Gastro-Duodenal Tubes
- Polyethylene Tubing
- GOLD SEAL Syringes & Needles
- Adams Stethoscopes
- JUSTRITE Wound Clips
- Obstetrical Manikins
- Skulls & Skeletons
- MEDICHROMES—2 x 2″ Kodachromes

Clay-Adams Company, Inc. 141 EAST 25TH STREET, NEW YORK 10, N. Y.

CLAY-ADAMS PRODUCTS ARE AVAILABLE FROM LOCAL SURGICAL AND SCIENTIFIC SUPPLY DEALERS

Today MORE THAN EVER

HOSPITALS ARE INSISTING ON

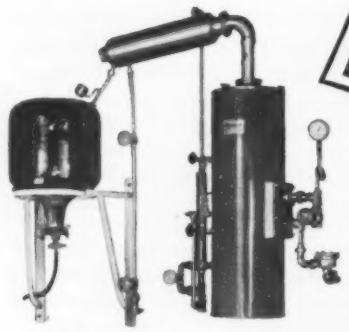
Barnstead DISTILLED WATER

TODAY, more than ever, hospitals are relying on Barnstead Stills for their distilled water. For the modern hospital must have an entirely dependable source of pure water for the central supply, pharmacy, solution, and operating room.

Hundreds of hospitals purchased Barnstead Stills during the past year. In fact, more hospitals purchased Barnstead Stills in 1950 than in any year of Barnstead's long history. The names of just a few are shown here — ample evidence of hospital confidence in the Barnstead Still.

When you specify a Barnstead Water Still for your hospital you too can be *sure* you have made a wise investment.

Write for Special Hospital Bulletin #116.



Water Purity is Always Measured by Barnstead Standards

Barnstead STILL & STERILIZER CO.

27 Lanesville Terrace, Forest Hills, Boston 31, Mass.

Oak Park Hospital, Oak Park
Ringgold County Hospital, Mt.
Rosary Hospital, Corning, Iowa
Boone County Hospital, Harrison
St. John Hospital, Santa Monica,
Washington County Hospital, Faye
Veterans Administration Hospital, W
Wabash General Hospital, Mount C
Menorah Hospital, Kansas City, Mo.
General Hospital, Lehighton,
Folk Hospital, Athens, Ga.
tal, Mt. Veron, Ohio Sioux
y Hospital, Dawson, Ga. Ve
ery, Mobile, Alabama St. Fra
ounty Hospital, Boise City, Oklah
Community Hospital, Wakefield, Ne
Callinger Municipal Hospital, Washington, D. C.
Veterans Hospital, Baltimore, Md. Washington C
Emanuel County Hospital, Swainsboro, Ga. Coya
Shelby County Hospital, Shelby, N. C. Rutherford
Allen County Hospital, Iola, Kansas Rochester State
Meriden Hospital, Meriden, Conn. Dickinson Memori
St. Lukes Hospital, Boise, Idaho Childrens Hospital, L
Deaconess Hospital, Freeport, Illinois St. Josephs Hosp
Baptist Hospital, Pensacola, Florida Bishop Clarkson Me
Samaritan Hospital, Waupe, Idaho South Bend Medical
Massie Memorial Hospital, Paris, Kentucky Self Memorial
Memorial Hospital, Modesto, California Sturgis Memorial
Glenn County Hospital, Willous, California Clay County Ho
Mt. Sinai Hospital, New York, N. Y. Farran Memorial Hospit
St. Margarets Hospital, Dorcester, Mass. Rush County Hospital, Le Cro
Bradford Hospital, Bradford, Pa. Memorial Hospital, Johnst
Montiefore Hospital, New York, N. Y. Long Beach Memorial Hospit
Yorktown Hospital, Yorktown, Texas Throckmorton County H
Wheaton Community Hospital, Wheaton, Minn. Southside Hospita
Newton Memorial Hospital, Newton, N. H. Stetion Hospital, Albuquerq
Cobb Memorial Hospital, Royston, Ga. Scripps Memorial Hospital, La
King County Hospital, Brooklyn, N. Y. Warren Hospital, Phillipsburgh,
Barrow County Hospital, Winder, Ga. Bannock County Hospi
State Hospital, Hastings, Minn. South Sunflower County Hospi
Appling County Hospital, Baxby, Ge.
Waynesboro Burke County Hospital, Waynesboro, Ga.
Debois County Memorial Hospital, Jasper, Indi
Clark's Summit State Hospital, Clarke S
Memorial Hospital, Springfield
Veterans Hospital, New O

Barnstead Leadership Is Based On Facts

1. The famed Barnstead Condenser — the only condenser that separates and expels gaseous impurities. Especially important in the solution room.

2. Scientifically designed evaporators which operate at low vapor velocity and have ample steam disengaging space. Distillate cannot be contaminated by raw water carry-over.

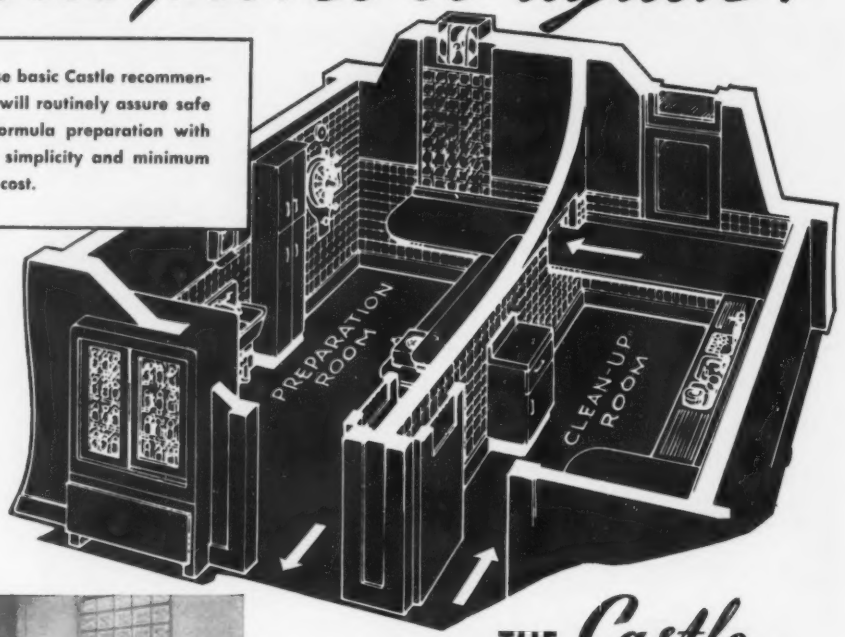
3. Spanish Prison Baffles remove minute entrainment and pyrogens. An exclusive Barnstead feature.

4. Barnstead Stills stay on the job for months between cleanings.

5. Wide selection — there is a size and type for every hospital, large or small.

Castle proves it again!

. . . These basic Castle recommendations will routinely assure safe infant formula preparation with greatest simplicity and minimum per-unit cost.



Where practical, as in Castle's recent Genesee Hospital installation, windowed storage refrigeration facilities afford practical supervisory advantages and visitors are happily impressed.

THE *Castle* MILK FORMULA ROOM TECHNIC

● Provides for meticulous cleansing, rinsing and draining of bottles, nipples and accessories within the area designated as the receiving or clean-up section . . . time and cost are saved by terminal sterilization in the concluding process.

● In the preparation section of the Formula Laboratory, terminal heating of bottled and nippled formulas at 230° F. for 10 minutes is sufficient to produce formulas that are bacteriologically safe . . . terminal sterilization permits the use of single door autoclave construction which offers a triple saving in cost, installation and personnel. Its safety concentrates all steps in one simple process.

FACILITIES TO MEET EVERY VOLUME REQUIREMENT

Our experienced Planning Department is available to assist the hospital, the architect or hospital consultant without charge. Planning the Milk Formula Room is an important phase of our business and we welcome your invitation to suggest ways and means most economically practical.

Address your inquiry to **WILMOT CASTLE COMPANY**
1175 University Ave., Rochester 7, N. Y.

Castle **STERILIZERS AND LIGHTS**

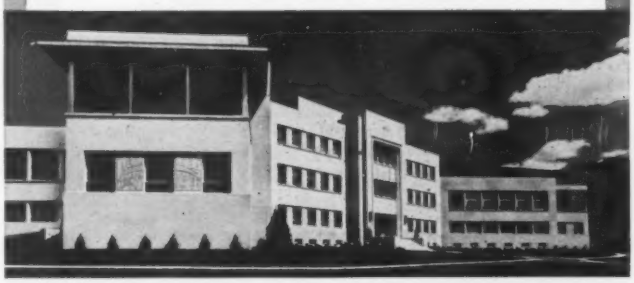
AMERICAN-Standard

First in heating . . . first in plumbing

It's AMERICAN-Standard plumbing fixtures in this modern hospital for crippled children

● In the Shriners Hospital for Crippled Children of Salt Lake City, Utah, American-Standard plumbing fixtures are on the job helping to lighten the work of staff and attendants . . . and adding to the comfort of patients.

There's a *complete line* of sturdily-constructed American-Standard heating and plumbing products, designed to meet the most rigid hospital requirements and to fill the most specialized needs. You can depend upon these quality products for flawless operation through long, hard service.



Architects: Scott & Beecher, Salt Lake City, Utah
General contractor: Olson Construction Co., Salt Lake City
Plumbing contractor: The H. G. Blumenthal Co., Salt Lake City

The Infants' Double Bath in this grouping is made of rigid cast iron for durability and has a thick coating of acid-resisting enamel for lasting good looks, It bathes two infants, with a 30" shelf for each; has two separate sprays, thermostatic control. The lavatory at left is made of easy-to-clean genuine vitreous china and has gooseneck spout and wrist-control fittings. The sturdy Clinic Sink is also made of permanently non-absorbent genuine vitreous china and has quiet, thorough siphon jet flushing action.

This Emergency Bath is sturdily constructed of rigid cast iron with a heavy coating of acid-resisting enamel. It is only 5" deep at the outlet and stands only 31" from the floor, providing a safe, convenient means of bathing stretcher cases.

These wall-hung Surgeons' Scrub-up Sinks are easy to clean, easy to clean around. And the smooth, non-absorbent genuine vitreous china fixtures retain their lustrous good looks indefinitely. They are equipped with handy gooseneck spouts and knee action mixing valves.

This bathing room is made more cheerful by colorful wall and floor decorations. It features a Master Pembroke Bath of rigid cast iron heavily coated with enamel, and a Lucerne Lavatory of genuine vitreous china. The wide, flat bottom of the tub facilitates bathing the children.

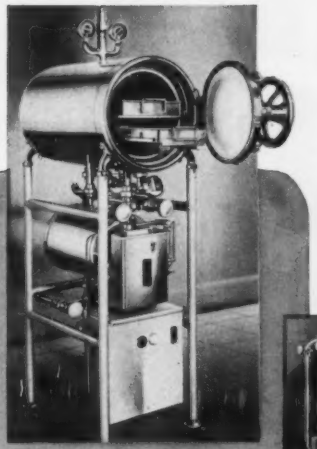
LOOK FOR THIS MARK OF MERIT

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.

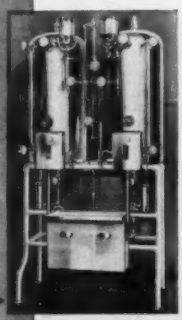
Serving home and industry

AMERICAN-STANDARD · AMERICAN BLOWER · CHURCH SEATS · DETROIT LUBRICATOR · KEWANEE BOILERS · ROSS HEATER · TONAWANDA IRON

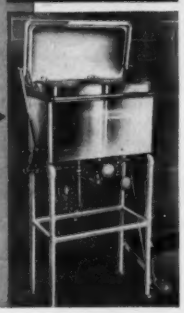
Do you know this important fact about Scanlan-Morris sterilizers?



▲ **MONEL PROTECTION.** Important features of this Scanlan-Morris cylindrical pressure sterilizer are its inner shell and steam jacket, its sturdy trays and racks. Made of Monel, they resist fatigue and corrosion.



LONG-LASTING SOURCE for sterile hot and cold water. These sterilizers have seamless tanks of Monel. Corrosion-resistant all the way through, Monel never needs painting, coating or costly periodic maintenance. ▶



ADAPTABLE. Made with body, cover and trays of rugged, corrosion-resistant Monel, models of Scanlan-Morris instrument sterilizers are available for heating by direct steam, gas, electricity — and even kerosene. This one is heated by steam. ▶

All these sterilizers are "immunized" against metallic ills.

They are designed to withstand heat, pressure, fatigue, water, steam, and hospital solutions.

They are built to give you dependable, 24-hour-a-day service year in, year out.

They are made of MONEL®.

What this means

In Monel, you have a solid, corrosion-resisting Nickel Alloy. Being solid, it protects your sterilizers *for life* against chipping, crazing or peeling.

The protection you get from Monel never ends because a surface becomes marred or wears away; the "surface" of Monel actually extends through the *full thickness* of the metal.

What's more, Monel is stronger and tougher than structural steel. It is hard and smooth. It resists gouging. Even your heaviest loads of bulky, keen-edged surgical instruments won't damage Monel's attractive satiny finish.

Maintaining sanitation

Monel is easy to keep bright and shining. Most of the time, plain soap and warm water will do the job. Occasionally, you may want to use a mildly abrasive cleanser or detergent. Go right ahead—it's safe. Remember, there's no scrubbing away Monel's good looks—*they're permanent.*

Monel construction is available in Scanlan-Morris cylindrical pressure-type surgical supply sterilizers, water sterilizers and non-pressure boiling-type instrument and utensil sterilizers.

Remember, though, that Monel is being diverted to vital defense uses, and only the most essential civilian needs are being met.

Write for details

For full information about the various types of Scanlan-Morris sterilizers that bring you all the solid advantages of Monel, write OHIO CHEMICAL & SURGICAL EQUIPMENT CO., a division of Air Reduction Company, Inc., 1400 E. Washington Avenue, Madison 10, Wisconsin.

MONEL. THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street, New York 5, N. Y.

...ALWAYS A WISE CHOICE FOR HOSPITAL EQUIPMENT

Take your pick of more than 1,200 prizes for your business or personal use. A television set, cutlery, luggage, Wear-ever pans, a camera, a beverage bar—any of these and more can be yours without an extra penny's cost! Just save the valuable coupons packed with almost all the General Foods Institution Products. And when you collect enough coupons for the prize you want, you send them in direct to General Foods. We rush the prize back to you. Easy, isn't it?

WRITE FOR FREE CATALOG LISTING PRIZES!

Now, before you forget, send a card or letter to: *General Foods Institution Prize Department, Box 121, Dayton 1, Ohio,* asking for your free Catalog listing the complete parade of prizes. You'll be in step with the best if you start saving your coupons today!

Products of General Foods

3 great **RUSCO** products designed to help you

improve buildings

increase comfort of occupants

reduce work

reduce maintenance

save fuel

RUSCO HOT-DIPPED GALVANIZED STEEL PRIME WINDOW ...FOR NEW CONSTRUCTION

A truly remarkable improvement in window engineering. Complete with glass, screen, insulating sash (optional) and wood or metal installation members. Factory-assembled, factory-painted, *ready to install!* Saves money on low initial cost, low installation cost, maintenance. Rusco Prime Windows can be installed in *minutes* instead of hours required for ordinary windows!

RUSCO GALVANIZED STEEL SELF-STORING COMBINATION SCREEN AND STORM SASH ...FOR MODERNIZING OR REMODELING

Installed without alteration to present windows. Provide rain-proof, draft-free, filtered-screen ventilation in every kind of weather. Eliminate danger of drafts or damage from rain or snow. Weatherproof the entire window opening, make sizable reductions in fuel costs. Glass inserts can be removed from inside for easy cleaning.

RUSCO GALVANIZED STEEL COMBINATION SCREEN & STORM DOOR ... BUILT FOR THE AGES

Handsome *and* practical! Made of sturdy triple-protected galvanized steel and finished with baked-on outdoor enamel. Won't sag, bind or warp. Lumite screen withstands abuse, can't rust or rot, never needs painting. Self-storing arrangement provides full glass insulation with lower screen for ventilation, as desired. Or, door can be converted *in seconds* to all glass or all screen!

Guaranteed by Good Housekeeping

These are just a few of the many Hospitals using RUSCO products:

Malden Hospital, Malden, Mass. • Mercer Cottage Hospital, Mercer, Pa. • The Huntington County Hospital, Huntington, Ind. Tecumseh Hospital, Tecumseh, Nebraska St. Elizabeth's Hospital, Youngstown, Ohio Nantucket College Hospital, Nantucket, Mass. • Mercy Hospital, Auburn, New York New England Hospital for Women & Children, Roxbury, Mass. • Newport Naval Hospital, Newport, Rhode Island • Valley View Sanatorium, Haledon, New Jersey.

For full information see your local Rusco Dealer, or write direct to

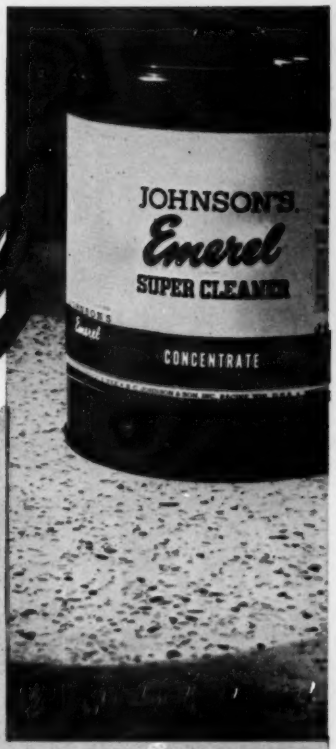
The F. C. RUSSELL Co.

DEPT. 6-MH 81 • CLEVELAND 1, OHIO

World's Largest Manufacturer of All-Metal Combination Windows

The New Super Cleaner Johnson's®

Emerel™



Cuts all dirt lightning fast... without scrubbing!

1. Just mop Emerel on. It cuts oil, dirt, grease instantly!

2. No scrubbing is necessary. Emerel does all the work . . . *in 1 minute or less!*

3. Remove the Emerel solution. With it comes *all* dirt, grime and surface stains!

Emerel is a revolutionary *fast-action* cleaner— developed by the makers of Johnson's Wax

Use Emerel on terrazzo . . . marble . . . ceramic and vitreous tile . . . concrete . . . wood . . . linoleum floors. Use it on walls and woodwork, too: on painted, sealed, enameled, porcelain, marble and tile surfaces. Emerel is fast, thorough, easy to use . . . the last word in safe, powerful, effective cleaners.

- Even in cold or hard water, Emerel acts instantly . . . cleans completely!
- Safe to use on any washable surface!
- Deodorizes thoroughly...leaves a clean, fresh, outdoor smell!
- Costs only pennies per gallon of solution!

Free demonstration!

Emerel makes your present cleaner out-of-date. Let us prove it to you. Mail coupon today!

S. C. JOHNSON & SON, INC.
Maintenance Products Dept. MH-8
Racine, Wisconsin

S. C. Johnson & Son, Inc.
Maintenance Products Dept. MH-8, Racine, Wisconsin

☐ Please arrange for a demonstration of Emerel. No obligation, of course.

☐ Please send further information on Emerel.

Name_____ Title_____

Firm_____

Address_____

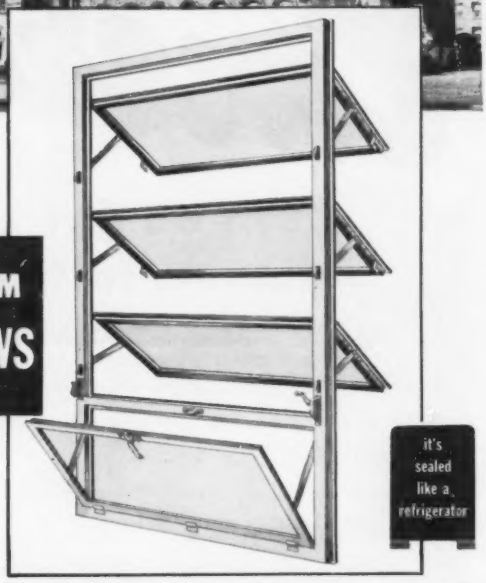
City_____ State_____

For Real WEATHER CONTROL

Auto-Lok ALUMINUM WINDOWS

PATENTED

weatherstripped



100% CONTROLLED VENTILATION — *when open*

TIGHTEST CLOSING WINDOW EVER MADE — *when closed*

The most important requisite in a hospital window is ***weather control.*** Never before in window history has there been a window that mastered all climatic extremes, as capably as Auto-Lok...America's perfect hospital window.

That's because these modern, versatile windows feature a unique draft control design that reduces air infiltration to an incredibly new low...thereby cutting down the danger of drafts or "cold spots" which invite respiratory ailments.

Both architects and hospital management are quick to recognize the operating economies Auto-Lok provides: reduced fuel bills—lowered air conditioning and maintenance costs—window cleaning time slashed, because they can be cleaned from the inside ...top vent, too...all proven factors in establishing Auto-Lok's tremendous acceptance among hospital architects throughout the country.

Also available — AUTO-LOK in Wood

AUTO-LOK SETS NEW STANDARDS FOR WINDOW PERFORMANCE — because it:

- provides positive protection against all climatic extremes.
- assures draft-free ventilation even when it is raining.
- harmonizes with every architectural style.
- can be cleaned entirely from the inside — top vent, too.
- reduces air-infiltration to only 0.095 cfm per foot.
- eliminates drafts—air scooped upward and inward.
- slashes fuel and maintenance costs.
- has removable inside screens and storm sash.

OUR ENGINEERING DEPARTMENT IS AT YOUR SERVICE

The fenestration experience accumulated over the years by our engineers, who have been privileged to work with hospitals, architects and managements in solving all types of window problems, is yours for the asking.

Pictured above:
DePaul Hospital School of Nursing
St. Louis, Mo.

Architects-Engineers
Maguolo and Quick
4909 Delmar St.
St. Louis, Mo.

We believe you will find our FREE booklet, "WHAT IS IMPORTANT IN A WINDOW?" both interesting and helpful. Address Dept. MH-8

LUDMAN CORPORATION

P. O. Box 4541 Miami, Florida

Small Hospital Questions

Malpractice v. Liability

Question: We are interested in knowing whether in the opinion of your company it is essential that a private nursing home carries malpractice insurance if it has liability insurance. Would you consider it malpractice or liability if a nurse would put a patient into too hot a bath?—A.B.R., N.Y.

ANSWER: There is no question about liability of a privately operated nursing home. When one is sued, the test of liability is the same as any other private corporation, namely, whether the corporation exercised due care in selecting the employe has no bearing if that person was negligent in performing the act.

A nurse cannot be held guilty of malpractice because the term refers to improper treatment or culpable neglect of a patient by a physician. She may, however, be held liable for negligence.

Ordinary liability policies do not provide coverage for professional acts. If a nurse placed a patient in too hot a bath, she could be held responsible for the resulting injuries on the ground she was negligent.—DON C. HAWKINS.

Power and Light Equipment

Question: What facilities should a hospital provide for emergency power and light as a measure of civil defense?—V.W., Wash.

ANSWER: This question cannot be answered conclusively. Circumstances and conditions permit various solutions. The least that should be considered is a bank of storage batteries to take care of operating, delivery and emergency rooms. This minimum protection should be imperative in any and every hospital regardless of possibility of bombing attack.

In every hospital there should be provisions for emergency lighting in case of ordinary power failure. I think this should be a part of all state and local wiring codes. Many hospitals have a dual system of power lines entering the hospital; that is, either two independent sources of power, or at least two independent systems of distribution from a central generating station.

In new constructions, provisions should be made for stand-by of not only operating, delivery and emergency suites, but corridors, stairways, fire exits, and so forth. There should be capacity for operating at least one elevator in buildings more than three stories high.

In existing hospitals, installation of stand-by equipment and necessary rewiring might involve large expense. Possibly a number of small generators or battery installations could be arranged for illumination of essential areas, and for operating essential motors such as pumps, heating and appliances. I believe the hospital standardization program has or will give this question its attention, and we may in the future have definite recommendations which, with the approval and cooperation of the National Fire Protection Association, may become official standards.—EDWARD J. TUCKER, *supervising engineer, Worcester City Hospital, Worcester, Mass.*

Reduce Electricity Cost

Question: The total amount we are spending for electricity increases every year, even though we have not added any major equipment. What can we do to reduce the cost of electricity in our hospital?—V.J., Mo.

ANSWER: As far as current consumption goes, we must realize that there has been a steady increase in recent years. The general level of illumination has been increased for most hospital areas. Many appliances have been added, such as refrigerated oxygen tents, electric food trucks, blood banks and other units which have added to the total hospital load. An increased number of employes in many departments also adds to the amount of electric current that is consumed.

Economy measures that can be undertaken include revision of illumination to reduce the size of lamps in such areas as corridors, interns' and nurses' residence quarters, stairways and other places where illumination can be diminished without loss of efficiency and without any safety hazard. Employes also can be instructed to turn off unnecessary lights after a given time at night. Such measures can reduce consumption as much as 15 per cent or more without loss, hospital experience shows.

Your utility company engineers will be glad to help you study the entire hospital problem with a view to increasing efficiency. One measure that may help is a study of the kilowatt demand in relation to kilowatt hour consumption. Sometimes the demand factor can be reduced by planning schedules so that all departments are not using the maximum amount of current at the same time. Proper metering also helps point the way to possible economies.

Hospital Staff Eligibility

Question: The county medical society here has a provision that a man is not eligible for membership until he has practiced in the county for a full year—unless he is transferred as a member in good standing from a society in some other county. This raises a question about hospital staff appointments in some cases. As a matter of practical procedure some of the hospitals in the county have gone ahead and appointed men who are not members of the county society. Is this good practice?—J.I.M., Va.

ANSWER: There is nothing wrong in appointing a qualified physician to the hospital staff even though he is not a member of the county medical society, and officers of the American Medical Association have agreed that society membership need not be requisite to hospital staff appointments. The important thing is that the physician shall be appointed on the basis of his qualifications and that he shall be granted hospital privileges and assigned hospital duties within the limits of his qualifications as determined by his training and experience.

Of course, it would seem to be a natural and wise thing to do for the credentials committee of the staff to have an informal discussion with appropriate officers of the county medical society in considering a candidate for staff appointment who is not a society member, to make certain that there is no question of professional competence or ethical conduct involved.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

GOLEMON & ROLFE, ARCHITECTS

St. Frances Cabrini Hospital — Alexandria, La. —an outstanding example of functional beauty that can be achieved with Concrete Joist Construction.

ALL OVER AMERICA, those responsible for building our hospitals are facing a challenging problem. Hospitals *must* be built *quickly*... yet materials and manpower are scarce. The need today is to make the *fullest* use of our total resources ... of men ... of material ... yes, the most effective use of money, too! St. Frances Cabrini Hospital met the need by using *Ceco Meyer Steelform Concrete Joist Construction*, which provides big savings these three ways:

1. SAVES MEN because less time and labor are required to provide open wood centering and form work.

2. SAVES MONEY by saving concrete... the "dead load" is kept to a minimum. Removable steelforms can be re-used, so only a small rental is charged.

3. SAVES MATERIAL because only a minimum of critical steel is used. Less concrete is necessary than in other concrete floor constructions.

The result... a strong, flexible building capable of absorbing great strain. It's fire-resistive ... SAFE; soundproof ... QUIET. *Ceco*, originator of the Steelform method, is first in the field. So when concrete joist construction meets your need call on *Ceco*... the leader over all.

CECO STEEL PRODUCTS CORPORATION

General Offices: 5601 West 26th Street, Chicago 50, Illinois

Offices, warehouses and fabricating plants in principal cities

CECO STEEL®

In construction products **CECO ENGINEERING** *makes the big difference*

A room like this painted according to Pittsburgh COLOR DYNAMICS will do much to raise a patient's morale and speed his recovery.

- **aids convalescence**
- **relieves eye fatigue in operating rooms**
- **increases efficiency of nursing staff**
- **reduces housekeeping problems**

4 big advantages that PITTSBURGH COLOR DYNAMICS will give your hospital!

MORE and more executives who operate hospitals and sanatoriums are becoming aware of the physical and psychological benefits to patients and staff as the result of the proper use of color.

● **This accounts** for the great interest among them in Pittsburgh's system of COLOR DYNAMICS.

● **This revolutionary method** of painting is based upon the *energy in color* and its influence upon human beings. Tests have proved that color can be used to stimulate or depress, to help people feel relaxed, more comfortable and cheerful.

● **In many institutions** where COLOR DYNAMICS has been applied, patients have been aided in speedier recovery. Medical and nursing staffs have done their work more efficiently.

● **By the use of COLOR DYNAMICS** patients' rooms and wards have been given color arrangements that assist convalescence. Purposeful use of color in operating rooms relieves eye-fatigue and tension in surgeons at their delicate tasks. Proper color at nurses' stations promote alertness and efficiency.

● **By the use of COLOR DYNAMICS,** it has even been shown that housekeeping and maintenance problems are simplified and lessened.

● **Why not use** this modern system of painting next time you paint and obtain these benefits for your institution? You'll find the complete story of COLOR DYNAMICS and how to use it explained simply and clearly in a brand new booklet which we'll be glad to send you *free.* It contains many practical suggestions in full color.

SPECIAL COLOR STUDY—FREE!

● We'll be glad to make a scientific color engineering study of your entire hospital for you without charge or obligation on your part. Call your nearest Pittsburgh Plate Glass Company branch and arrange to have one of our trained staff of color experts see you at your convenience. Or mail this coupon.

SEND FOR A COPY OF THIS BOOK!

Pittsburgh Plate Glass Co., Paint Div., Department MH-81, Pittsburgh 22, Pa.

☐ Please send me a FREE copy of your Booklet *"Color Dynamics."*

☐ Please have your representative call for a Color Dynamics Survey without obligation on our part.

Name_____

Street_____

City_____ County_____ State_____

PITTSBURGH PAINTS

PAINTS • GLASS • CHEMICALS • BRUSHES • PLASTICS

PITTSBURGH PLATE GLASS COMPANY

23 Reasons Why

15,000 Armstrong X-4 Baby Incubators are now in use

1. Low Cost (Still no increase in price)
2. Underwriters' Laboratories Approved (X-4 is the first baby incubator to be UL tested and approved.)
3. Accepted by American Medical Association
4. Tested and approved by Canadian Standard's Association
5. Simple to operate
6. Only 1 control dial
7. Heat—safe and low in cost. (Costs no more than burning an electric light bulb)
8. Easy to clean
9. Quiet and easy to move.
10. Casters have ball bearings and soft rubber treads (two have foot brakes)
11. Fireproof construction (Metal, asbestos and glass)
12. Safe and simple oxygen tent.
13. Welded steel construction
14. 3-Ply safety glass (No plastics)
15. Full length clear view of the baby.
16. Simple oxygen connection (With inside rotary directional control—a new feature)
17. Small night light over control.
18. Both F. and C. thermometer scales
19. Safe locking top ventilator
20. Automatic heat and humidity control
21. Easy to develop high humidity
22. The finest automatic thermoswitch that money can buy
23. Over 15,000 now in use

Write for prices and descriptive bulletin.

THE GORDON ARMSTRONG COMPANY, INC.

Division JJ-1 Bulkley Building, Cleveland 15, Ohio

Distributed in Canada by Ingram & Bell, Ltd.

Toronto • Montreal • Winnipeg • Calgary • Vancouver

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AMERICAN MEDICAL ASSOCIATION

C.S.A. APPROVAL NO. 7307

UL LISTED UNDER RECLAMATION SERVICE OF UNDERWRITERS' LABORATORIES, INC.

"Back of every Armstrong X-4 Baby Incubator is over 15,000 incubators' worth of experience."

wire from Washington

OLD FOLKS' PLAN

The administration's plan for hospitalization-at-age-65 has stirred up new interest in an old problem—and one, incidentally, that would not be solved by this newest proposal. Under the proposal formally advanced by Federal Security Administrator Oscar Ewing, persons 65 and over who were entitled to social security benefits would be allowed 60 days' federally financed hospitalization a year, as would certain other younger groups receiving social security benefits.

However, the plan would not allow benefits to be paid to domiciliary or rest homes, and before a chronically ill person could be admitted to a hospital, a physician would have to certify that the patient required hospital care. Thus aged, chronically ill members of the population would be placed under rather awkward limitations as far as the "free" hospitalization is concerned. There are two phases to the problem:

1. **If domiciliary or rest-home care** is sufficient for an aged, chronically ill patient, this would not be allowed; there could be no government payment unless and until the patient had been admitted to a certified general hospital, where the cost per day might be several times that of another type of institution.

2. **Both physician and patient** would be placed on the spot. Unless the physician could certify that the chronically ill patient actually needed more attention than he could receive in a domiciliary or rest home, the patient himself or his relatives would have to pay the bill.

It is estimated that 5,500,000 persons aged 65 or over would be eligible for the hospitalization, with enough widows and dependents to make a total just under 7,000,000. However, the chronically ill aged (not including obesity, hearing or vision cases) also make up a substantial total, estimated by Public Health Service at 5,000,000 persons. Some of these would be covered by the plan, though not for domiciliary or rest home care, but several million others certainly would not be entitled to any benefits.

Many religious and racial organizations now care for thousands of aged and chronically ill persons at heavy expense. They are interested in seeing the administration's plan broadened to include at least some of their charges, but so far there is no indication that Federal Security Agency officials expect to liberalize the regulations in this direction. When he announced the program, Mr. Ewing said he had talked it over with officials of American Hospital Association and Catholic Hospital Association, but he did not say they had endorsed it.

BATTLE OF THE V.A. (Cont'd)

Along with other legislation piled up in House and Senate are recommendations of the Humphrey subcommittee for a realignment of medical activities in the Veterans Administration. Whether any action at all will be taken on them at any time is problematic. For the time being, it is quite certain that Congress will do nothing drastic. The issues already have become too deeply involved with politics to allow rapid and logical solution.

The report itself implied that all parties concerned were pretty well in agreement as to what changes should be made. However, almost as soon as copies of the report were available, V.A. Administrator Carl Gray Jr., issued his own statement. It criticized the conduct of the Senate subcommittee and declared that the major legislative changes were either unnecessary or inadvisable.

Gray said the report gave a distorted view of his testimony and that of Vice Adm. Joel T. Boone, who became chief medical director after Dr. Paul Magnuson was ousted last January. The V.A. administrator said the suggestions for strengthening the authority of the chief medical director would mean setting up a separate entity within V.A. He objected to vesting the medical chief with "primary authority" over the hospital program.

With this as background, Congress is expected to consider the following legislative changes:

1. **Amend the law** so as to "leave no doubt whatever" that Congress intends the chief medical director to be the principal medical authority of the agency with primary authority to control, manage and operate its medical and hospital program.

2. **Provide that the medical director** be appointed by the President, with Senate confirmation. (Currently he is appointed by the V.A. administrator, which made possible the ouster of Dr. Magnuson by General Gray without opportunity for appeal.)

3. **Realign functions** of V.A.'s special medical advisory group as follows: The group to be enlarged to take in representatives of the public, veterans and "eminent authorities in the respective health professions," including members of the deans' committees, who were so effective in bringing about close working relationships between V.A. hospitals and medical schools. Furthermore, the group would be recreated as a permanent commission, authorized continuously to review the V.A. medical and hospital programs and to report at least annually to the administrator as well as the chief medical director.

NEW NURSE POLICY

Dismal result of the campaign for recruiting army nurses has brought about a new Defense Department policy statement which should prove heartening to nurses in and out of the military services. Most of the points are just what nurses' associations have been advocating for many years. Henceforth, all military services will be governed by the following:

1. **Ward and dispensary nurses** will be relieved of routine housekeeping, clerical, supply, food service and other non-professional duties.

2. **Operating rooms, central supply** sections and other hospital departments will at all times be staffed according to the number of nurses needed to perform professional duties.

3. **The three military medical services** will be expected to train sufficient nonprofessional personnel—military, practical and auxiliary—to assume the less technical duties now performed by registered nurses.

4. **Registered nurses** no longer will be trained and utilized as dietitians, physical therapists and occupational therapists.

5. **Women from the armed services**—WACS, WAVES, WAFS or medical service corps personnel—will be assigned to the chief nurse's office of each large hospital for administrative work.

6. **Full authority and responsibility** for the nursing service will rest with the chief nurse of each hospital, and the appropriate nursing officers will participate in designing and planning future military hospitals.

7. **Military nursing** henceforth will be regarded as an identifiable service, performed by several categories of professional and nonprofessional personnel.

Recommendations originated with the Armed Forces Medical Policy Council, which had the assistance of the national nursing organizations in its study of the military nursing shortage problem.

SUPPLIES

Regulations (and the alphabetical agencies that issue them) are changing too fast for most hospital administrators to keep up to date. No one wants to make work of hospital administrators any tougher than necessary, but regulations inevitably mean a pyramid of policies, explanations and exemptions. Whatever else they learn about federal controls, administrators are advised to remember this: For construction authorization, for help in getting scarce material and equipment for every problem concerned with supplies, consult Division of Civilian Health Requirements, Public Health Service—that is, if you can't get needed assistance in your own town or state.

For those who want to (or have to) go into more detail, here are a few of the more recent trends:

Tighter allocation of steel, copper and aluminum are anticipated for the fourth quarter of this year, but there still is a possibility that regulations will be relaxed for some types of construction; experience has shown that the material conserved doesn't always justify the cumbersome controls. DO-45 ratings, formerly used for hospital construction, have been abandoned and replaced with CMP (controlled materials plan), with the form F-3 for hospital and school construction. CMP-4C has likewise replaced the old NPAF-24 form used for construction permits; CMP-4C serves both as an application for authority to start construction and an application for actual allocation of material and equipment. In another form shift, the familiar DO-97 order used by hospitals for obtaining maintenance repair and operating supplies has been replaced by "DO-MRO."

Hospitals like other purchasers eventually will be affected by decisions being worked out every day by scores of I.A.C.'s—industrial advisory committees—meeting with price stabilization officials. It would be fruitless to attempt a complete listing of what is taking place at these I.A.C. meetings, but here are some examples: A number of committees representing manufacturers of various categories of rubber products (some sundries, dipped rubber gloves and rubberized fabric gloves included) worked out a tailored price regulation formula with stabilization officials; percentage adjustments will be made on their base period price. In so doing, the committees waived the right to small increases at this time. Technically, each manufacturer will compute his new ceiling prices on each item by multiplying his own base period price by the factor common to the entire industry. Stabilization officials say that, with one exception, the new prices will be no higher than at present.

Under another agreement, manufacturers of paints, varnishes and lacquers were allowed to rescale their prices by taking into account the past year's sizable cost increases. Shelf brands likely will be increased, but not drastically, while prices to contractors and industrial users probably will be rolled back an undetermined amount. Members of the "Cups and Nested Containers Industry Advisory Committees" (beverage cups and food containers used extensively in hospitals and other institutions) agreed on the third quarter of 1949 as the best base period, but asked stabilization officials to make a spot-check survey of industry prices. They said increases would be justified under the latest manufacturers' general ceiling price regulation, but indicated they preferred to defer any adjustment until a tailored regulation could be drafted, based in part on the proposed survey.

Civilian Health Requirements, P.H.S., says hospital industries are not following the suggestion that copies of appeals to NPA for larger allocations under CMP be sent to the division for follow-up. "We have repeatedly recommended to industry that they send us a copy of all such appeals. But to date, we have received only a few," said Coordinator Charles G. Lavin last month. "Where P.H.S. has had copies it has been able to help obtain needed relief," he added.

A breakdown of CMP assistance for hospitals is foreseen unless allocations consider basic construction, building and other needs in addition to the comparatively small requirements coming under the heading of "professional supplies." One manufacturer reported his steel allocation for the third quarter of 1951 would furnish only 29 per cent of his needs for civilian hospitals.

FEDERAL FODDER

National Bureau of Standards researchers have produced what they describe as "a durable, lasting pigment for marking clinical thermometers." It is a silicon resin formulation that is said to withstand cleansing with soap and phenol solutions far better than any other known pigment. In tests at the bureau, the formulation withstood more than seven months' continuous or intermittent exposure to a large number of disinfectants, soap solutions, detergents and other chemicals. It is now available commercially.

Private duty nurses, whether working in homes or hospitals, are not subject to wage regulations; officially they are regarded as independent contractors.

To avoid difficulties in collecting for services to military personnel, hospitals are advised to study a fact sheet issued by Defense Department's office of public information. It details current policy on authorization and payment of civilian medical care for army personnel while on leave in localities where there are no federal hospitals. Some points: First-aid treatment authorized at any time, with payment guaranteed by the federal government. Bills should be submitted to patient's commanding officer or military authority who approved the service. No surgical operations without prior approval of military authorities, except in an emergency.

Looking Forward

A Loss for Labor

IT IS hard to understand what labor hopes to accomplish by strikes against hospitals. At any time under any circumstances, public opinion has always been solidly opposed to action which threatens the safety or comfort of hospital patients, as a strike always must. When strike tactics include not only work stoppage and picketing but violent assaults on hospital workers and officials, as the hospital strike in Minneapolis did last month (see page 51), the only possible result for the union must be a ruinous loss of public confidence.

The dispute at Minneapolis was about wages, but the underlying issue was the union shop. Hospital representatives declined to resolve the wage difference as long as labor insisted on a union shop agreement. While the union shop must certainly be differentiated from the closed shop in the degree of control over employment practice that is relinquished to union authority, there is no question that management authority is diluted somewhat under a union shop contract—a concession that hospitals have consistently refused to grant.

Events in Minneapolis have proved that hospital representatives were wise to insist on maintaining full control over employment, dismissal, advancement, wages, union membership and all the other details of the employer-employe relationship. If union and hospital officials were equally devoted to the welfare of hospital patients, the quality of service would be given first consideration in every evaluation of employe performance, and some responsibility and authority in connection with conditions of employment could be passed from management to unions without any resulting hazard to patients. As it turns out, this is not the case—in Minneapolis, at any rate. The Building Service Employes Union there has plainly indicated its disregard for patient welfare. Regardless of the merits of the wage dispute, the union is condemned and defeated by its own tactics, and the cause of union labor in hospitals everywhere must suffer accordingly.

The Fire Story

AS REPORTED in *Collier's* magazine for July 14, 1951, the hospital survey which is being conducted by the National Board of Fire Underwriters with the cooperation of the American Hospital Association has revealed that 90 per cent of hospitals inspected present some kind of fire hazard. The headline ("Our Firetrap Hospitals") and lead story ("Sister Edmunda smelled smoke," etc.) of the *Collier's* article were nicely calculated to scare hell out of anybody who is going to be a hospital patient. The rest of the article should scare hell out of hospital people.

The survey has not yet been completed and no official report has been released, but the results as summarized by the *Collier's* writer were based on "nearly completed tabulations" reviewed by the writer in the national board's offices. Among other things, they indicated that 85 per cent of the general hospitals inspected (every hospital of 50 beds or more will be covered by the time the survey is complete) are not fire retardant; 95 per cent have no fire drills or active evacuation plan; 95 per cent have open stairways or elevator shafts; 95 per cent have defective wiring; 80 per cent have "inadequate" sprinkler protection; 95 per cent have fire alarm systems that failed to function properly; 75 per cent have "nothing approaching adequate self-inspection" for fire hazards; 90 per cent had inadequate

protection against static sparks in the operating room, and 70 per cent had combustible materials unsafely stored.

In a communication to *Collier's*, the American Hospital Association protested that hospital fire losses "have been exaggerated in the public mind out of all proportion to the number which have occurred." Articles about hospital fires, the association stated, "tend to destroy public confidence in one of the nation's most vital services." At the same time, the association urged its members to take advantage of the *Collier's* article to build public interest in hospital fire safety—by calling attention to safe features and practices which have been introduced and by pointing out inadequacies in order to attract the financial support needed to take corrective steps.

Certainly many hospitals are unsafe because they lack the money to install fire-doors or sprinklers or to make other needed structural changes. But not all these hospitals have investigated the savings in insurance premiums that can be effected through improved safety installations and practices, and few if any have made fire safety the focal point of public education or fund-raising programs. Until these things have been done, inadequate financial means remains a poor excuse for the existence of correctible fire hazards.

Furthermore, as the *Collier's* article and national board officials have pointed out, the most important factors in hospital fire safety don't require an investment in building or equipment. "It is the human factor which determines whether a hospital is safe or a firetrap," said the chairman of the board's hospital committee. "Hospital conditions are bad because of human ignorance, neglect and carelessness. New hospitals or even expensive structural changes in old buildings are usually not so important to safety as good administration in existing facilities. A hospital is only as safe as safe practices make it."

Unquestionably, the *Collier's* article will cause some hospital patients to lose sleep. That is too bad. But a hospital whose employes are untrained and unpracticed in their fire safety duties is a hospital whose administrator shouldn't be able to sleep.

Bad Publicity

THE fact that some 5 per cent of doctors caring for insured poliomyelitis patients were making excessive charges for their services was recently headlined by a Chicago newspaper. Medical society officials in Chicago protested the newspaper's story, claiming that the entire medical profession would be blamed even though only a few doctors were guilty, that Chicago physicians were unduly singled out, and that anyway medical societies now have grievance committees charged with responsibility for handling complaints about excessive fees.

We can easily understand and sympathize with the feelings of the ethical physician who finds himself blamed or suspected for the sins of a few unethical colleagues, but we cannot agree that exposure of medical evils should be suppressed altogether because of the possibility that some unjust inferences might be drawn from such publicity. The very fact that all doctors may suffer some loss of public confidence and prestige when the sins of a few are publicly revealed offers the principal hope that wrong practices can be eliminated. The doctor who finds his own patients and friends looking at him sideways following a public exposure of fee-splitting, kickbacks or excessive charges is likely to take a militant attitude toward the offenders; until he does this, there isn't much chance that they can be found and punished.

As the Chicago physician who protested the publicity about the polio cases pointed out, the medical society's own grievance committee is a constructive step toward the elimination of excessive fees. But the grievance committee can't function until someone presents evidence of overcharging. Most patients don't know such committees exist; this means that the committee, however well conceived and sincerely motivated, is effective only in the occasional case that is brought to its attention.

Doctors who are really interested in wiping out medical wrongdoing of all kinds should welcome the assistance of newspapers, magazines and others who are finding and presenting evidence of wrongdoing. In the same way, hospital people and their associations should recognize the necessity for discovering and exposing the few institutions that are guilty of loading patients' bills with excessive charges. The feeling that "bad" publicity about doctors and hospitals destroys public confidence is probably exaggerated. Unless the facts are completely misrepresented, the only kind of confidence that can really be destroyed by publicity is misplaced confidence. The thing that hurts hospitals and doctors most is not bad publicity but bad practices.

Calling Dr. Beep

SEE where some hospital has new-fangled doctors' call system," Anastasia remarked chattily the other day, shoving aside the fifth or sixth pile of papers so she could sit down on our desk. "How's it work?" she wanted to know.

Well, each doctor has this little radio receiver that he puts in his pocket as soon as he comes into the hospital, we explained. Then, when the operator has a call for a certain doctor, she sends a beep from her transmitter over his particular wave-length. He hears the beep and goes to the nearest phone to take his call, see?

"I'm against it," Anastasia said promptly. We asked why.

"Destroy public confidence medical profession, hospitals," she replied. We didn't get it. Anastasia slid off the desk and headed for the door.

"What's hospital where nobody's calling Dr. Kildare?" she asked scornfully. "Imagine a movie called 'Beep'!"

Unidentified pickets argue with a nurse who is trying to enter Fairview Hospital.

Acme Photo

LABOR GETS ROUGH *in Minneapolis strike*

but goon tactics fail as service continues in 10 struck hospitals and striking workers return to jobs

MINNEAPOLIS.—Saturday, July 7, was the most irritating day—to that date—of the Minneapolis summer. Belated heat and humidity encased the city, putting human tempers to the Torrid Test. Storm warnings were out, and it looked as if, before the Sabbath came, all hell might break loose.

Inside 10 voluntary hospitals, an intolerable administrative tempo was entering its 12th consecutive day. In the service departments fatigue-befogged regular employes were moving mountains of work, but the output of volunteers and jittery new workers was spasmodic because of unfamiliarity and—now—fear.

This was the chaotic situation as hospitals and the building service union wrangled over demands for a closed shop, a 5 (to 15) cents an hour raise, and a 40 hour work week with two consecutive days off and with no split days or split shifts.

On the picket lines outside these 10 hospitals, roughing tactics had edged over into sporadic violence. Intrepid administrators, major and minor, were literally pulling their employes off the sidewalks and into the grounds. Even nuns scuffled with pickets, emerging triumphant but not unscathed. Incredible as it may seem, one Reverend Sister showed a gaping courtroom the print of a nail in her palm. In rescuing a graduate nurse who had been pushed to the ground, the Sister had been struck by someone with a picket sign and a nail on the sign punctured her palm. For the first time in ecclesiastical history, a publicly exposed nail print was quickly reshielded by a Band-Aid.

To turn back the calendar by one leaf, on June 26 some 500 unionized employes of the 10 hospitals took an unscheduled "vacation." This exodus represented only 50 per cent of the workers in the specific classifications involved and roughly 90 per cent of the union membership in these classifications.

By July 5, although some of these had returned to their laundry machines, elevators, kitchens, wards and grounds, the "vacation" walk-out had been officially declared a strike by the A.F.L. Central Labor Union in Minneapolis, and mass picketing by Building Service and Hospital and Institutional Employes Union No. 113 had begun. Minnesota has a law forbidding strikes against charitable hospitals.

On the afternoon of July 6, the 10 struck hospital plants—Asbury, Abbott, Eitel, Lutheran Deaconess, Fairview, Parkview, Northwestern, St. Mary's, St. Barnabas and Swedish—took their mushrooming problems to court, seeking an injunction against Local No. 113.

Judge D. E. La Belle heard some convincing evidence that afternoon, but it took the sunrise events of July 7 to bring the strike pattern into an integrated but revolting design.

By MILDRED WHITCOMB

Acme Photo

Striking hospital workers stop bread truck from crossing picket line at Fairview Hospital. Food supplies were brought to the struck hospitals by various means.

When the besieged administrators steamed into the courtroom that morning, huddled about them was a convoy of uniformed nurses, interns, orderlies and nurses' aides, housekeeping maids in checked ginghams, and assorted males in shirt sleeves. These comprised Exhibit A. All had been jostled or manhandled by pickets as they reported for the morning shift. In the case of several hospitals, Exhibit B was a nail collection, picked up from ambulance entrances where they had been sown by strikers from passing cars. Exhibit C might be a couple of sawed-off baseball bats, such as Supt. Alvin Langehaug retrieved from Fairview Hospital's hedge.

On the witness stand, the stories all tallied: (1) interference with normal deliveries; (2) abusive language; (3) threats of violence to employes, administrative personnel, visitors and incoming patients; (4) attempted sabotage of ambulance and automobile tires; (5) sidewalk scuffles, and (6) compounding instances of violence. Big-time goon business, including an anonymous threat of murder, was to come a few days later.

The more spirited pickets were, as one might surmise, The Girls, old, young and medium. The Girls were equally adept at pushing around the Boss or the bus boy, a Nun or a nurses' aide. The men strikers, except for a valiant few, carried their strike banners shyly, preferring a daybreak or a sunset shift.

Hospital administrators agreed wholeheartedly on their choice of villain in the plot—Norman E. Carle, secretary-treasurer of Local No. 113. Not a commanding figure sitting at headquarters directing grand strategy was he; Carle was right in there punchin'. Somebody suspiciously like Carle slapped the 79 year old janitor of Northwestern Hospital on the opening morning of the strike, but the slapper's identity couldn't be established.

Now, on this seething July 7, an orderly at Swedish Hospital tangled with two pickets as he came on the job. David Elfstrand, a university student, was the man assaulted. Two men were scuffing him up when a squad car swung around the corner, and all three were hauled off to the station.

Minneapolis is a union town; no one denies it. Mayor Eric Hoyer still holds a union card, and the aldermanic majority is union. On the opening day of the walk-out the city fire department came to the hospitals' rescue, telling the strikers in plain American: "The garbage is going out and no funny business! See?" They saw. But the police department held back, feeling its position was ill defined.

When Young Elfstrand and his attackers appeared before the police chief, the culprits' names came out. Elfstrand was not impressed but Ray Swanson, head of Swedish Hospital, was rocked back on his rubber heels when he learned that one of his orderly's assailants was Carle himself.

GIVEN POLICE ESCORT

The palavering at police headquarters stretched on to 45 minutes, arriving nowhere, and the orderly began to worry about the men on his ward. Finally he said as much, and the chief replied: "Sure, kid, go on to work."

Retorted the 18 year old orderly: "I'll go to work all right, but if some goon bashes in my head, I'll hold the police department responsible." For this brash remark, Elkstrand won a police escort to the hospital.

Norman Carle could not have been detained long by the police for when a representative of The MODERN HOSPITAL appeared at the Labor Temple shortly after 9 a.m., a moody Carle was sitting behind the locked front door staring into dismal space.

In response to sign language, an office girl unlocked the door. It was a surly secretary-treasurer who came forward when the girl was asked to present a spokesman for the union's case. Carle's welcome was the curt suggestion that the reporter ride right back to Chicago where all the information was available from the Central Labor Council. (Chicago has no central labor council and the Building Service Employes Union has dodged all telephone calls in regard to Minneapolis.)

At this point a venomous issue of

Volunteer workers at St. Barnabas Hospital learn how to wield a mop and bucket in the absence of the regular employes. Volunteers are Mrs. Stephen Wyer, Wayzata, Minn., and Ann Warner, of Dallas, Tex.

Acme Photo

the *Local No. 113 Reporter* was picked up from a display rack; this Carle speedily slipped from the reporter's hand and suggested that the whole story was better told in another issue which contained the signed agreement and wage scales of three St. Paul hospitals—St. Luke's, Children's and Miller—and better it was. (The souped-up issue was later recovered when Carle was called to the telephone. It had to do with the "viciousness of the hospital employers" and the "abominable Labor Baiters MacAloon, Donald Peterson, Nye, Swanson" and other unnamed members of the local hospital council.)

The reluctant Carle soon began to defrost, charging that Swedish and Abbot hospitals are directed by groups that are conniving to wreck Local No. 113 and that they have "leverage" over the others. St. Mary's, St. Barnabas, Asbury and Parkview have their hands tied, he said.

"EMPLOYES BECAME RESTLESS"

Negotiations on a new contract have been going on for 21 months, he declared, and some of the employes justifiably had begun to get restless and impatient and had walked out.

"Department heads were beginning to get obnoxious, refusing reasonable items. They were getting more officious every day.

"As for the hospital administrators," Carle continued, "they would come to meetings called by the conciliator and just sit and talk about the weather. We could get nowhere."

When the union employes walked out on June 26, hospital administrators announced that these employes had quit their jobs, Carle went on. Under Minnesota law, he said, when there is a labor dispute no one quits and no one is fired.

"Now with these debutantes and society dames, the hospitals will get nowhere," Carle growled with great bitterness. "You know the long cigaret-holder type—they don't mix with menial tasks. They'll work eight hours today, four hours tomorrow, and then they'll fade away.

"Naturally the girls don't object to having their pictures taken with a tray in their hands, and if they are holding onto a patient's pulse—that's lovely.

"As for the high school kids they've hired, they won't work. Kids are lazy—just like my kids and your kids. They don't really care about work."

Shop steward at Northwestern Hospital holding back a nurses' aide (in light coat). Women picketers were more spirited in their tactics than were the men.

Photograph by Tommy Lee

Then Carle described what the hospital administrators later confirmed. So much bad blood had been engendered between the union and the hospital administrators that Mayor Hoyer had hit upon an astute way of getting a decision. He asked each of the hospitals to send a board member, who had not been involved in the negotiations, to a meeting of Associated Industries. This body picked five men from the 10. Meanwhile the Central Labor Union was asked to select five members of unions representing other industries. This put the whole dispute in the hands of two policy making groups, whose decision could be final and binding. These groups met daily for two weeks with the state labor conciliator in the mayor's office in an effort to break the impasse.

Carle then related how during the third week in May, the 10 hospitals had posted a notice to their employes of a 5 cents an hour wage increase, which as far as money benefits were concerned, was all the union was seeking at the time. However, the contract between hospitals and union had expired on March 1, and there had been precedent for making the pay raise retroactive to that date. The hospitals went hardly half-way, making the increase retroactive to April 19.

This "unilateral action" enraged the union. After the strike was officially declared on July 5, the union retaliated by stepping up its demands and seeking a 15 cents an hour increase (10 cents additional).

Carle further contended that the hospitals are violating the 1949 arbitration award, which established a five-day consecutive work week with two consecutive days off. Exception to this rule, the union charges, can be made only upon mutual agreement individually arrived at between union and hospital involved.

(*Continued on Page* 134.)

Students at the university acting as head cooks at St. Barnabas. Left to right: Delores Johnson and Kathleen Bye, of the University of Minnesota.

Acme Photo

Measuring Hours of Nursing Care

PER PATIENT PER DAY — EVERY DAY

JOSEPH E. BARNES
and
EDGAR L. GEIBEL
Assistant Directors
Genesee Hospital
Rochester, N.Y.

DOES your hospital maintain a daily record of the number of hours of nursing care furnished per patient?" This question evokes few responses; the pattern of these ranges from the complete record system whereby the administrator receives a daily report from each nursing unit to no system whatsoever.

We recognize that the measure of the amount of nursing care in terms of hours per patient per day is not a new procedure for determining the adequacy of a nursing service. For many years, nursing surveys and hospital consultants, as well as many hospitals, have been using this measure as an index of the nursing service in a hospital. Since many hospitals do not maintain such a record on a day-to-day sequence, consultants and survey teams usually have selected a predetermined period for study, instructed the hospital on the necessary procedure and, on the basis of the period selected, formed an opinion upon which to judge the nursing service of a hospital.

The obvious question which we now would raise is, that, if it's a sound basis for consultants and survey teams to judge a hospital, why is it not a sound basis for an administrator and nursing service director to have it at their finger tips daily?

AS ADMINISTRATIVE TOOL

A daily report of the hours of nursing care per patient per day is a valuable administrative tool for both management and the nursing service. For the nursing service, it provides an opportunity for the nursing service director to maintain the desired balance (either by choice or necessity) between professional and subsidiary workers in each nursing unit. Also, it serves as a method of quickly spotting overstaffing.

Overstaffing may be an unfamiliar term to recent graduates in nursing, but in our recent surveys we have discovered that in certain hospitals a nursing unit may be furnishing eight or nine hours of nursing care per patient per day. In the ordinary course of events, this certainly is overstaffing. By utilizing a daily report, the director of nursing service can spot such discrepancies and prevent a recurrence. Likewise, understaffing may quickly be ascertained and subsequent transfers from other units to provide the necessary coverage can be accomplished if the personnel is available. For obvious shortages in certain nursing units, the figures serve to strengthen the director's plea to the administrator.

For the hospital administrator, a daily record of the number of hours of nursing care furnished per patient per day is an invaluable administrative tool, provided he receives it! In a few minutes each day (10 minutes for a 200 bed hospital), he can quickly review the staffing of each nursing unit. When ratios appear to be "out of line," he may ask for enlightenment from the director of nursing service. The mere fact that the nursing service is aware that a review of its staffing takes place in the administrator's office will make the department more conscious of its responsibilities.

Financially, too, it behooves the ad-

PLACE THIS EDGE ON THE LINE DIRECTLY BELOW THE FLOOR CENSUS NUMBER AT THE LEFT

THE GENESEE HOSPITAL, ROCHESTER, NEW YORK

HOURS PER PATIENT APPEARS HERE ↗

The computation table on the opposite page shows the floor census in the lefthand column and the number of hours worked on the top line. By applying the square outlined on this page with the bottom edge directly below the floor census number and the righthand edge beside the nearest number of total hours worked one can quickly compute the hours of nursing care furnished.

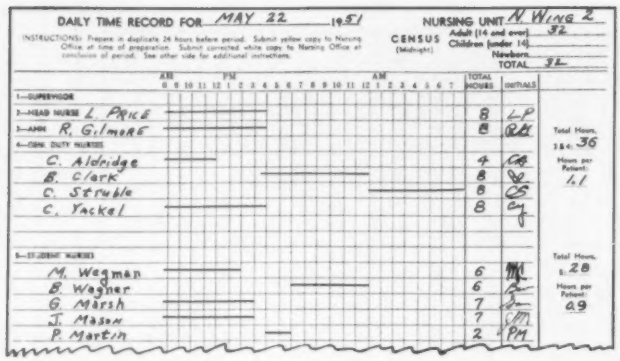
↑ **Place this edge to the right of the nearest total number of hours worked appearing at the top.**

TABLE FOR COMPUTING NURSING HOURS PER PATIENT PER DAY

NUMBERS ON TOP LINE INDICATE TOTAL HOURS WORKED

THE GENESEE HOSPITAL, ROCHESTER, NEW YORK

Floor Census	4	8	10	12	14	16	18	20	22	24	26	28	30	32	34	36	38	40	44	48	52	56	60	64	68	72	76	80	84	88	92	96	100	105	110	115	120	125	130	135	140
8	.5	1.0	1.3	1.5	1.8	2.0	2.3	2.5	2.7	3.0	3.3	3.5	3.8	4.0	4.3	4.5	4.8	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5														
9	.4	.9	1.1	1.3	1.6	1.8	2.0	2.2	2.4	2.7	2.9	3.1	3.3	3.6	3.8	4.0	4.2	4.4	4.9	5.3	5.8	6.2	6.7	7.1	7.6	8.0	8.4	8.9	9.3	9.8											
10	.4	.8	1.0	1.2	1.4	1.6	1.8	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4	3.6	3.8	4.0	4.4	4.8	5.2	5.6	6.0	6.4	6.8	7.2	7.6	8.0	8.4	8.8	9.2	9.6									
11	.35	.73	.9	1.1	1.3	1.5	1.6	1.8	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.3	3.5	3.6	4.0	4.4	4.7	5.1	5.5	5.8	6.2	6.5	6.9	7.3	7.6	8.0	8.4	8.7	9.0	9.5							
12	.33	.66	.85	1.0	1.2	1.3	1.5	1.7	1.8	2.0	2.2	2.3	2.5	2.7	2.8	3.0	3.2	3.3	3.7	4.0	4.3	4.7	5.0	5.3	5.7	6.0	6.3	6.7	7.0	7.3	7.7	8.0	8.3	8.8	9.2	9.6					
13	.3	.62	.77	.92	1.1	1.2	1.4	1.5	1.7	1.8	2.0	2.2	2.3	2.5	2.6	2.8	2.9	3.1	3.4	3.7	4.0	4.3	4.6	4.9	5.2	5.5	5.8	6.2	6.5	6.8	7.1	7.4	7.7	8.1	8.5	8.8	9.2	9.6			
14	.30	.57	.7	.85	1.0	1.1	1.3	1.4	1.6	1.7	1.9	2.0	2.1	2.3	2.4	2.6	2.7	2.9	3.1	3.4	3.7	4.0	4.3	4.6	4.9	5.1	5.4	5.7	6.0	6.3	6.6	6.9	7.1	7.5	7.9	8.2	8.6	8.9	9.3	9.6	
15	.26	.53	.67	.8	.9	1.1	1.2	1.3	1.5	1.6	1.7	1.9	2.0	2.1	2.3	2.4	2.5	2.7	3.0	3.2	3.5	3.7	4.0	4.3	4.5	4.8	5.1	5.3	5.6	5.9	6.1	6.4	6.7	7.0	7.3	7.7	8.0	8.3	8.7	9.0	9.3
16	.25	.5	.65	.75	.9	1.0	1.1	1.3	1.4	1.5	1.6	1.8	1.9	2.0	2.1	2.3	2.4	2.5	2.8	3.0	3.3	3.5	3.8	4.0	4.3	4.5	4.8	5.0	5.3	5.5	5.8	6.0	6.3	6.6	6.9	7.2	7.5	7.8	8.1	8.4	8.8
17	.24	.47	.6	.7	.8	.9	1.0	1.2	1.3	1.4	1.5	1.7	1.8	1.9	2.0	2.1	2.2	2.4	2.6	2.8	3.1	3.3	3.5	3.8	4.0	4.2	4.5	4.7	4.9	5.2	5.4	5.6	5.9	6.2	6.5	6.8	7.1	7.4	7.6	7.9	8.2
18	.22	.44	.55	.65	.8	.9	1.0	1.1	1.2	1.3	1.4	1.6	1.7	1.8	1.9	2.0	2.1	2.2	2.4	2.7	2.9	3.1	3.3	3.6	3.8	4.0	4.2	4.4	4.7	4.9	5.1	5.3	5.6	5.8	6.1	6.4	6.7	6.9	7.2	7.5	7.8
19	.21	.42	.55	.65	.75	.8	1.0	1.0	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.3	2.5	2.7	2.9	3.2	3.4	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.1	5.3	5.5	5.8	6.1	6.3	6.6	6.8	7.1	7.4
20	.20	.4	.5	.6	.7	.8	.9	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.4	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.3	5.5	5.8	6.0	6.3	6.5	6.8	7.0
21	.19	.38	.5	.6	.7	.8	.9	1.0	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.1	2.3	2.5	2.7	2.9	3.0	3.2	3.4	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.5	5.7	6.0	6.2	6.4	6.7
22	.18	.36	.45	.55	.65	.7	.8	.9	1.0	1.1	1.2	1.3	1.4	1.5	1.5	1.6	1.7	1.8	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.3	3.5	3.6	3.8	4.0	4.2	4.4	4.5	4.8	5.0	5.2	5.5	5.7	5.9	6.1	6.4
23	.17	.35	.45	.5	.6	.7	.8	.9	1.0	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.7	1.9	2.1	2.3	2.4	2.6	2.8	3.0	3.1	3.3	3.5	3.7	3.8	4.0	4.2	4.3	4.6	4.8	5.0	5.2	5.4	5.7	5.9	6.1
24	.16	.33	.4	.5	.6	.7	.8	.8	.9	1.0	1.1	1.2	1.3	1.3	1.4	1.5	1.6	1.7	1.8	2.0	2.2	2.3	2.5	2.7	2.8	3.0	3.2	3.3	3.5	3.7	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.4	5.6	5.8
25	.15	.32	.4	.5	.55	.7	.7	.8	.9	1.0	1.0	1.1	1.2	1.3	1.4	1.4	1.5	1.6	1.8	1.9	2.1	2.2	2.4	2.6	2.7	2.9	3.0	3.2	3.4	3.5	3.7	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.4	5.6
26	.15	.31	.4	.45	.55	.6	.7	.8	.9	.9	1.0	1.1	1.2	1.2	1.3	1.4	1.5	1.5	1.7	1.8	2.0	2.2	2.3	2.5	2.6	2.8	2.9	3.1	3.2	3.4	3.5	3.7	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.4
27	.14	.3	.35	.45	.5	.6	.7	.7	.8	.9	1.0	1.0	1.1	1.2	1.3	1.3	1.4	1.5	1.6	1.8	1.9	2.1	2.2	2.4	2.5	2.7	2.8	3.0	3.1	3.3	3.4	3.6	3.7	3.9	4.1	4.3	4.4	4.6	4.8	5.0	5.2
28	.14	.29	.35	.45	.5	.6	.6	.7	.8	.9	.9	1.0	1.1	1.1	1.2	1.3	1.4	1.4	1.6	1.7	1.9	2.0	2.1	2.3	2.4	2.6	2.7	2.9	3.0	3.1	3.3	3.4	3.6	3.8	3.9	4.1	4.3	4.5	4.6	4.8	5.0
29	.13	.28	.35	.4	.5	.6	.6	.7	.8	.8	.9	1.0	1.0	1.1	1.2	1.2	1.3	1.4	1.5	1.7	1.8	1.9	2.0	2.2	2.3	2.5	2.6	2.8	2.9	3.0	3.2	3.3	3.4	3.6	3.8	4.0	4.1	4.3	4.5	4.7	4.8
30	.13	.27	.35	.4	.45	.5	.6	.7	.7	.8	.9	.9	1.0	1.1	1.1	1.2	1.3	1.3	1.5	1.6	1.7	1.9	2.0	2.1	2.3	2.4	2.5	2.7	2.8	2.9	3.1	3.2	3.3	3.5	3.7	3.8	4.0	4.2	4.3	4.5	4.7
31	.12	.26	.3	.4	.45	.5	.6	.6	.7	.8	.8	.9	1.0	1.0	1.1	1.2	1.2	1.3	1.4	1.5	1.7	1.8	2.0	2.1	2.2	2.3	2.5	2.6	2.7	2.8	3.0	3.1	3.2	3.4	3.5	3.7	3.9	4.0	4.2	4.4	4.5
32	.12	.25	.3	.4	.45	.5	.6	.6	.7	.8	.8	.9	.9	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6	1.8	1.9	2.0	2.1	2.3	2.4	2.5	2.6	2.8	2.9	3.0	3.1	3.3	3.4	3.6	3.8	3.9	4.1	4.2	4.4
33	.11	.24	.3	.35	.4	.5	.5	.6	.7	.7	.8	.8	.9	1.0	1.0	1.1	1.2	1.2	1.3	1.5	1.6	1.7	1.8	1.9	2.1	2.2	2.3	2.4	2.5	2.7	2.8	2.9	3.0	3.2	3.3	3.5	3.6	3.8	3.9	4.1	4.2
34	.11	.24	.3	.35	.4	.5	.5	.6	.6	.7	.8	.8	.9	.9	1.0	1.1	1.1	1.2	1.3	1.4	1.5	1.6	1.8	1.9	2.0	2.1	2.2	2.4	2.5	2.6	2.7	2.8	2.9	3.1	3.2	3.4	3.5	3.7	3.8	4.0	4.1



DAILY TIME RECORD FOR MAY 22 1951 — NURSING UNIT N. WING 2

INSTRUCTIONS: Prepare in duplicate 24 hours before period. Submit yellow copy to Nursing Office at time of preparation. Submit corrected white copy to Nursing Office at conclusion of period. See other side for additional instructions.

CENSUS (Midnight): Adult [14 and over] 32; Children [under 14]; Newborn; TOTAL 32

	AM 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 PM 1 2 3 4 5 6 7	TOTAL HOURS	INITIALS	
1—SUPERVISOR				
2—HEAD NURSE L. PRICE		8	LP	
3—ASSN R. GILMORE		8	RG	Total Hours 36
4—CLINICAL DUTY NURSES				
C. Aldridge		4	CA	Hours per Patient 1.1
B. Clark		8	BC	
C. Struble		8	CS	
C. Yackel		8	CY	
5—STAFF NURSES				Total Hours 28
M. Wegman		6	MW	
B. Wagner		6	BW	Hours per Patient 0.9
G. Marsh		7	GM	
J. Mason		7	JM	
P. Martin		2	PM	

Daily Report Form on which names of floor workers and their schedule of hours are entered. Following her tour of duty, the employe enters her initials.

ministrator to keep abreast of his hospital staffing. With more than two-thirds of the hospital budget expended on labor and with the greater portion of this amount located in the nursing service, a yardstick of some kind is in order.

Primarily, however, a record of the hours of nursing care furnished per patient day provides a comparison of one nursing unit with another in the hospital and with existing norms or "hours wanted," as suggested by such reports as "A Study of Nursing Service in One Children's and Twenty-One General Hospitals"[1] and the 1950 "Hospital Nursing Service Manual"[2] prepared by the American Hospital Association and the National League of Nursing Education. Understandably so, it provides a relative measurement of the degree of competence of the supervision existing on the nursing unit.

However, we are under no illusion that the measurement of the quantity of nursing care provided is a true index of the adequacy of a nursing service. At the moment, though, it would appear to be the most suitable method available. Until such a time as we are able to measure the quality of nursing care furnished, we must needs utilize the tools at hand.

After much discussion and consideration, we have arrived at an opinion, biased as it may be by our own experiences, on why more hospitals do not maintain such a daily report. We think the fear of the mechanics of gathering the figures and the computation, together with the thought that it may be time consuming, is the greatest obstacle. We had these same apprehensions in the early days when we wanted a daily report of the hours of nursing care furnished per patient per day. Our early efforts utilized duplicated forms and much work on a comptometer, which was time consuming, to say the least.

As an aid to those hospitals that might still be reluctant to tackle the job on a daily basis, we are submitting our system for acquiring the data and performing the computation. We hold no brief for the thought that our procedures are original, for they are not; variations are practiced by many hospitals of our acquaintance.

GENESEE PLAN

Pads of Daily Report Forms are placed on each nursing unit for use by the charge nurse. These forms are 8½ by 11 inches with spaces allotted for the names of each worker by numbered category, *i.e.* staff nurses, student nurses, subsidiary workers, and so on. These forms also serve as a floor schedule.

For example, the charge nurse on Monday enters the names of the floor workers by categories and the schedule of hours they will work on Tuesday. This form is prepared in duplicate, one copy remaining on the floor and the other copy going to the nursing service office. This enables the nursing office to preview the work schedule for Tuesday. If no changes are suggested by the nursing office, the schedule stands.

On Tuesday, after her tour of duty, each worker enters her initials after her name. On Wednesday morning, the charge nurse totals the number of hours worked in each category and enters the figure in the category total space. The floor census for the day is also entered on the form. If work schedules have been changed during the day, the charge nurse alters the form and forwards it to the nursing office. In larger hospitals, a "snap-out" set in triplicate may be adopted with the third copy going to the nurses' residence as a schedule for the bulletin board for the subsequent day.

At the nursing office, a secretary reconciles the suggested schedule with that actually worked. Since the floor census and each category total has been entered on the form, it takes a very few minutes for the secretary to compute the hours of nursing care furnished per patient day for each category of workers on each nursing unit. This computation has been speeded up tremendously by the use of a computation table and a "square" for quickly determining the ratio.

Upon completion of the computation, one copy is taken to the administrator's office and one copy remains in the nursing office. Thus, by mid-afternoon of Wednesday the administrator has a factual report of the quantity of nursing care furnished on Tuesday in each nursing unit. In like manner, the administrator, *every day*, has a report of the nursing care provided on the previous day.

The copy that remains in the nursing office is used for pay-roll purposes as a record of hours worked, each worker having initialed the form attesting to his presence, which is substantiated by the charge nurse.

The administrator's copies are accumulated during the month. At the conclusion of the month, a summary is prepared for each nursing unit listing the total hours worked in each category. This summary serves as a basis for the cost department's making a direct allocation of nursing expense on this unit for arriving at a per diem cost. Holes at the top of each form enable them to be placed on a pegboard and speed up the work of summarizing.

In addition to their original purpose, these forms now serve as work schedules, pay-roll bases, and cost accounting aids.

[1] A Study of Nursing Service in One Children's Hospital and Twenty-One General Hospitals. New York: National League of Nursing Education.

[2] Hospital Nursing Service Manual. New York: American Hospital Association and National League of Nursing Education, 1950.

Architect's rendering of the expanded medical center. The executive architect for the teaching hospital is Milton T. Pfleuger, and for the medical sciences building, Blanchard and Maher. Both are located in San Francisco.

AN IDEAL MEDICAL SCHOOL *is the goal*

of the University of California Medical Center

BECAUSE medical schools and teaching hospitals have considerable responsibility in helping to improve the health and welfare of the country, an attempt is being made by the University of California to share some of this responsibility. The annual output of physicians, according to the National Security Resources Board, is entirely inadequate to meet the military and civilian needs. With the objective of increasing the output of professional personnel consistent with maintenance of high quality in education and research, the University Medical Center is undergoing extensive changes .

Groundbreaking was begun in July 1950, to encompass a developmental plan calling for the expenditure of $22,630,000. One large segment consisting of three increments of this construction program includes a 14 story medical sciences building. This structure will house administrative offices of the professional schools of medicine, dentistry, pharmacy and nursing, as well as the basic science departments of the school of medicine, laboratories and classrooms of the several schools.

Emphasis is given to providing space for teaching and research laboratories, and they are so designed that fundamental research facilities in the medical sciences building will be on the same floor adjacent to the clinical facilities of the hospital. A new library, an expanded record room to serve all the campus, as well as an auditorium wth a seating capacity of 450, will be included. The completion of the expanded plant will permit the school of medicine to increase its present enrollment from 288 to 400, or from 72 to 100 per class.

It is not inappropriate to mention that World War II interrupted construction and that impetus was given to planning after the national emergency. No doubt the delay is helpful to the extent that it permitted observation of new changes in medical technics and services.

Another large addition included in the building program is the 12 story Herbert C. Moffitt Teaching Hospital named by the regents of the university in honor of a former dean and professor of medicine in the school of medicine. This facility will be constructed as an integrated unit of the medical sciences building and will cost approximately $7,742,000. The present contract calls for a 14 story building, the interior of the two top floors to be left unfinished. If the 14 stories are completed at the outset the bed capacity would indicate 483, excluding infant bassinets. If only 12 floors are completed the bed capacity would be 387 excluding bassinets.

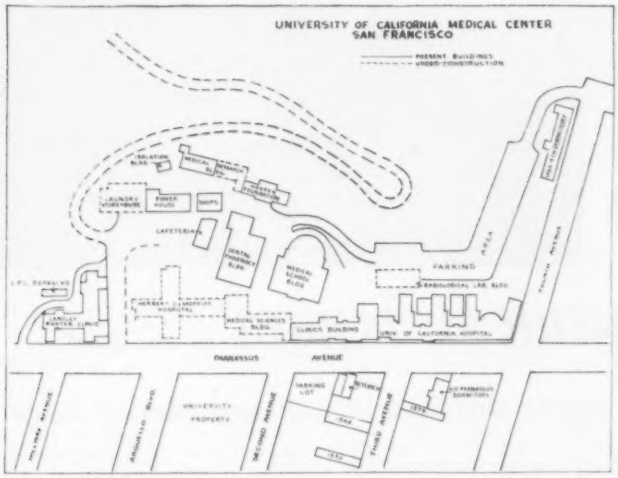
While many areas of the state of California have good county hospitals, facilities are not always available to care for the difficult medical and surgical cases which the university can well accept as teaching patients. The increased number of beds will permit acceptance of many more of these patients and thereby aid our teaching program.

The hospital is the heart of the medical school and under the modern methods of medical education the student learns by caring for hospital patients under the close supervision of older skilled physicians. The more patients there are available for study and treatment, the better equipped are the young physicians to handle the problems they will meet in practice; in a large hospital, under the direction of competent teachers, medical students can accumulate the equivalent of years of practice in their relatively brief period of formal study. This, then, is one more reason why the university is expanding its facilities: that the ideal medical school may be accomplished.

The hospital will be constructed on the cruciform pattern; the shape was selected since it appeared to all concerned in the planning that it achieves for us the most advantages and allows the most efficient flow of materials and traffic to the patient areas. The cross-shaped building permits greatest possible use of the central core principle with patients located in three wings and the fourth wing containing offices for the connecting medical sciences building. It facilitates placement of mechanical features, such as elevators, dumb-waiters and tube systems, and provision for food service, linen

WILLIAM BRYAN HALL

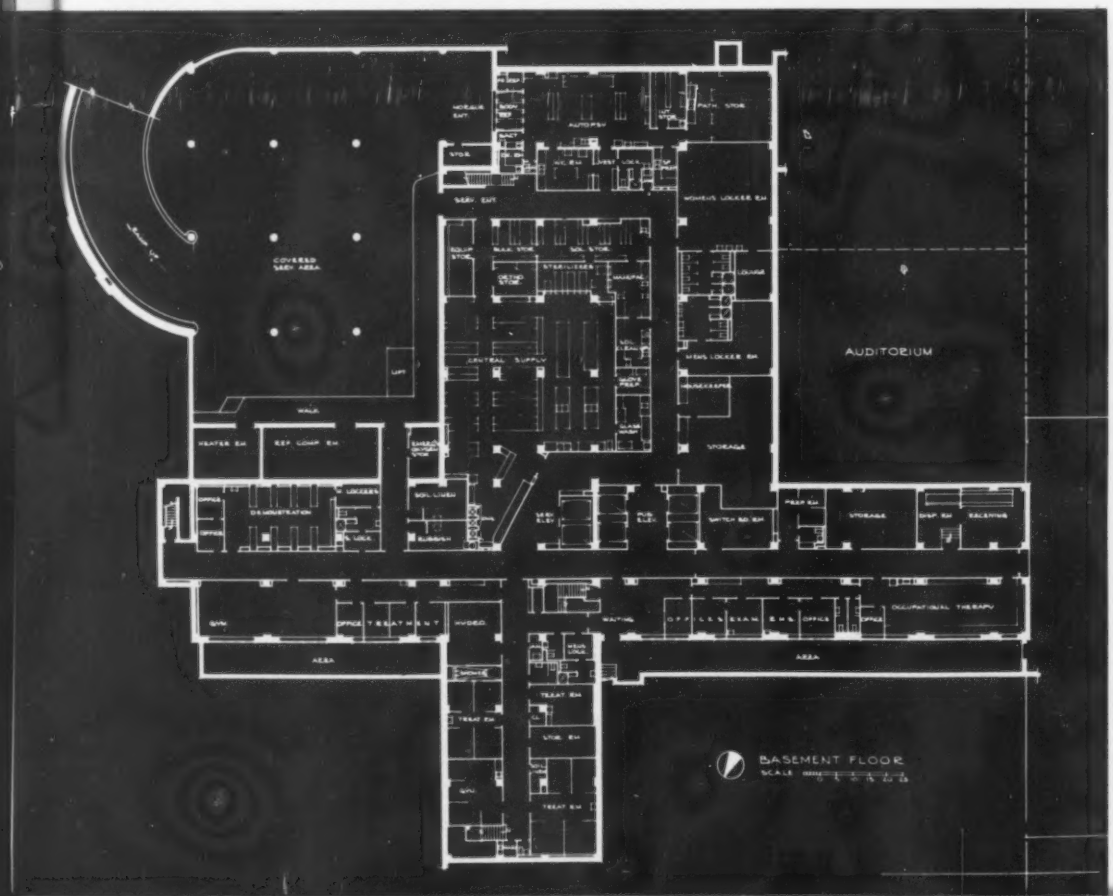
Administrator, University of California Hospital, San Francisco



The plot plan above shows the relation of the new Herbert C. Moffitt Hospital and the Medical Sciences Building to the rest of the center. The basement floor of the Moffitt Hospital, below, contains the central supply room; physical medicine and occupational therapy departments; housekeeping department, and employes' locker rooms. The first floor (opposite page) houses the admitting areas and various administrative units.

handling, and a most efficient use of nursing stations.

The buildings are models of modern planning, designed only after years of investigation and research. Installation of the latest equipment to permit modern technics will be incorporated in this general teaching hospital. Some of the interesting features are: (1) central oxygen system providing for oxygen to be piped directly to the operating rooms and bedside; (2) the communication system which will include two types of pneumatic tubes, a 4 inch tube with 40 stations and a 3 by 12 inch tube with 13 terminals to be used for transporting records, requisitions, charge slips, and the like; (3) intercommunicating nurse-patient call system; (4) audible doctors' paging system with stations so located as not to disturb patients; (5) automatic self-leveling elevators to include telephones and loud speakers; (6) a paging system with the control board located in the P.B.X. switchboard room. The board is to be of such size that 500 names will appear on the panel.



OUTLINE OF CONSTRUCTION DETAILS

STRUCTURE: Reinforced concrete, structural steel frames with spandrel trusses, concrete floors and roofs.

FLOOR AREA: Total net area for 12 floors, 189,000 sq. ft.; total gross area for 12 floors, 306,000 sq. ft.

HEIGHT: Basement, 12 floors and mechanical penthouse, floor to floor height of 13 feet. Alternate: Basement, 14 floors and machinery penthouse, floor to floor height, 13 feet. The basement and first 12 floors to be finished and fully equipped; the remaining 13th and 14th floors to be left unfinished.

WALLS: Exterior walls, reinforced with terra cotta facing. Majority of interior walls, plaster over metal lath. Some walls in service areas, glazed tile.

ROOF: Built-up roof with asphalt and gravel, perforated asphalt saturated asbestos felt cemented to roof deck for insulation. Super "A" 20 year roof.

WINDOWS: Aluminum projected. All windows curtained.

DOORS: Exterior, aluminum. Interior, flush panel, solid core wood birch veneer doors.

FINISHES: Conductive terrazzo in all operating rooms, scrub-up rooms, and surgical corridors. Ceramic tile wainscot in all pantries, toilets, baths and service rooms. Linoleum floor and base in remaining corridors and all bedrooms. Terrazzo floors and structural glazed tile wall in all kitchen areas.

LIGHTING: Flush ceiling mounted fluorescent fixtures in most cases.

INTERCOMMUNICATING SYSTEM: Entire building equipped with nurses', patients', doctors' intercommunicating system and pneumatic tube system. A 4 inch pneumatic tube connects all floors and departments of teaching hospital to adjacent medical sciences building. A 3 by 12 inch tube system connects medical sciences building record room with all outpatient departments.

PLUMBING: Copper water tube pipes with cast bronze streamline fittings. Oxygen piped to all bedrooms and nitrous oxide piped to operating rooms.

HEATING: Ward and bedroom areas to be supplied with tempered air in corridors and exhausted mechanically. Additional heating to be supplied by thermostatically controlled convectors in each room. Service areas to be supplied with heated air, thermostatically controlled by zones. Mechanical exhaust to be provided.

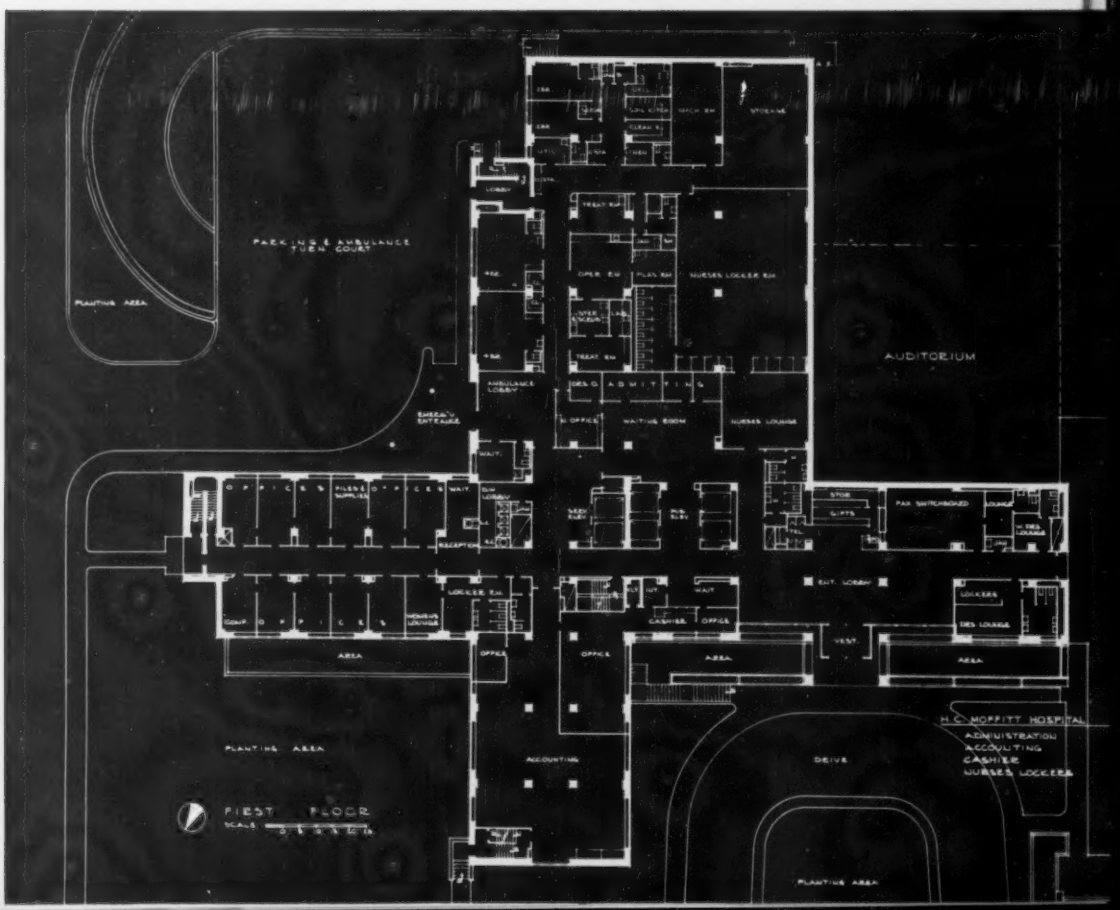
VENTILATION: Tempered forced air supply system to majority of occupied areas of building with corresponding exhaust system. Where radiators or convectors are used for heating, supply air temperature will be approximately 65°F.

AIR CONDITIONING: Cooling and humidity control to be provided for surgery and other critical areas. Air supply to be filtered by electronic filters for air-conditioned and other critical areas, and by nonelectronic type for all noncritical areas.

ELEVATORS: Four public elevators and two service elevators with a capacity of 4000 lbs. and a speed of 600 ft./min. will service all floors of the buildings.

SUMMARY: The following summary is for the completed 12 story structure including all fixed equipment. The cost of the unfinished 13th and 14th floors is not included in these amounts.

Building cost including fixed equipment	$7,742,000.00
Cost per bed including fixed equipment	$20,005.00
Total sq. ft. area	306,000
Total sq. ft. per bed	792
Cost per sq. ft. based on total building cost	$25.30
Total cubic feet	3,991,000
Cost per cubic foot	$1.95



Below: a typical patients' floor. Each floor will contain 58 beds in units not larger than four beds and will be handled by a twin connected nursing unit so arranged as to provide service through ward clerks. Each nursing unit is responsible for one half of the 58 beds. Above: The third floor is given over to the x-ray department, and contains the latest and most modern equipment available for diagnosis and treatment of patients.

A light alongside the doctor's name will signify his presence, while another one, when lighted, will signify a message is to be given.

Located on the basement floor is the central sterile supply room which will communicate by dumb-waiters and tube systems with all the nursing units on the floors above. This floor will also include space for physical medicine, autopsy and morgue, locker rooms, housekeeping office and storage areas for hospital equipment. A covered service area is adjacent to this floor. This area is approached by a ramp from the ground level and is used for service purposes.

12 BED EMERGENCY UNIT

Entering the lobby on the first floor, one has access to the admitting areas, administrative offices, the cashier and accounting departments, lounge rooms, gift and flower shop, emergency and observation unit of 12 beds for both adults and children, comprising an operating room, treatment rooms and isolation area.

The second floor includes all facilities for central food service; main kitchen, dining rooms, special diet kitchen, formula rooms and coffee shop, four high speed dumb-waiters for transportation of meals, and a tray conveyor for the return of soiled dishes to the dish-washing area. The entire dietary department is designed to facilitate instruction as well as service.

The third floor is entirely given over to x-ray, including both diagnostic and treatment units. The latest and most modern equipment available will be included in this department.

The fourth floor will include 10 operating rooms, some designed for the televising of operations and equipped with complete x-ray facilities and postoperative recovery rooms.

Located on the fifth floor will be various laboratories, tissue pathology, clinical laboratories, cardiograph, basal metabolism, blood bank and a number of offices. Acetylene and propane gas piping from outside the building for the use of flame photometers will be installed.

Stepping into one of the six high speed elevators, one is taken to the bed areas located on the sixth to the fourteenth floors, inclusive. Each one of the floors will contain 58 beds in not larger than four-bed units and will be handled by a twin connected nursing unit so arranged as to provide service through ward clerks, each

nursing unit being responsible for one-half of the 58 beds. Much consideration has been given to the nurse who feels the impact of the shortened stay. Areas are provided on each floor for utility rooms, subutility rooms, bathrooms, flower rooms, consultation rooms, space for storage of wheel chairs and ward equipment. Patients' clothing will be deposited in individual recessed lockers provided in the rooms to which the patients are assigned.

All ward floors have service kitchens where food trays are received and soiled dishes returned. Between meals nourishments may be stored in the service kitchens. Soiled dishes will be returned via a vertical tray conveyor to the kitchen and transferred mechanically to an overhead horizontal conveyor to the dishwashing area.

LAUNDRY TO SERVE CAMPUS

Linen supply for the day will be maintained in linen rooms on each bed floor, all to be processed in a new laundry building separated from the hospital. This laundry will be large enough to serve all units of the medical center as well as to handle the laundry work for the total Berkeley campus, 15 miles distant.

Pleasing and restful colors for the comfort of all have been selected to conform to textures, wall coverings, tiles and floor coverings throughout the hospital.

The clock system throughout the building is a self-regulating electronic type.

The approach to the hospital will be artistically landscaped to conform to the drive-in entrance and the rest of the hillside campus.

The power plant for the production of heat, light and power, together with separate maintenance shops, are well located on the campus within easy reach of the hospital. The expanded plant will necessitate construction of additional corporation yards, a larger incinerator and more parking area for automobiles and rerouting of underground utilities.

The present University of California Hospital, now comprising 289 beds and 30 bassinets, will be converted to the care of private patients. This, together with facilities now under construction and our close association with the Langley Porter Clinic for acute psychiatric care, will provide slightly under 1000 beds for the University of California Medical Center, San Francisco.

Below: Ten operating rooms, plus postoperative recovery rooms and x-ray facilities, are housed on the fourth floor. Some of the operating rooms are designed for televising surgical procedures. The corresponding floor in the medical building will be devoted to pathology and bacteriology. Above: The fifth floor will contain various laboratories: tissue pathology, clinical, cardiograph, basal metabolism, blood bank and a number of offices.

Three respirator ward patients are shown in varying degrees of convalescence. The special duty nurse is one of seven furnished during a 24 hour period through the cooperation of the National Foundation for Infantile Paralysis, Inc.

The RESPIRATOR WARD

is popular with the "colonists"

RALPH M. HUESTON
Superintendent
Wesley Memorial Hospital
Chicago

THE 1950 polio season in Chicago and Cook County was a severe one and left in its wake a large number of new respirator cases, patients who must have the benefit of the specialized kind of treatment necessary to bring paralyzed respiratory muscles back to normal. Wesley Memorial Hospital is cooperating with the National Foundation for Infantile Paralysis to afford group therapy for these stricken people, and has established a "respirator ward" for this purpose.

NEED CONSTANT CARE

A respirator ward is set up for the purpose of providing group care for patients in need of this type of service. Because of the almost complete helplessness of these patients owing to their difficulty in breathing, it is necessary to have trained personnel in attendance at all times. This factor sometimes presents a problem since some hospitals are reluctant to accept a patient whose condition is so precarious as to require constant attendance by the nursing staff plus special duty nurses. In any event, a common complaint by hospitals is that there are not enough nurses to go around, and that special duty nursing service around the clock is a costly process. By the establishment of a respirator ward at Wesley we have moved toward a happier solution of the problem.

In grouping respirator patients we have found the answers to many other questions concerning their care. Although a polio patient may be able to afford a private room and a special duty nurse, he is always lonely and apprehensive. Yet to place him in a general ward with other patients might interfere with the morale of his neighbors. The continual noise of the respirator and the precarious condition of the patient have proved to be a constant source of worry to others not so seriously ill.

In order to bring about better patient morale, reduce the cost of nursing care, and maintain the care of respirator patients with fewer trained employes, the national foundation attempts to group them in hospitals whenever possible. The initial step in grouping was taken at Wesley last year and the results proved so satisfactory that the foundation has urged other large Chicago hospitals to place all such patients in the same type of ward.

It has been found that the patients and their families are much better satisfied with this arrangement because there is a certain comradeship existing among persons whose infirmities are similar. The quality of care is not lessened by the fact that the Cook County chapter is furnishing seven nurses per day for four patients instead of three nurses per patient per day as would be necessary in a private room. Even with this setup, the cost of complete care for hospital service plus share of special nurse service for each of these patients is around $900 per month.

The care of a respirator patient is definitely a serious responsibility from the hospital's point of view, one reason being that there is no possible means of telling just how long the period of hospitalization will be. The foundation estimates that the stay may run a minimum of one year to an unknown maximum dependent upon the patient's needs. The trend is to wean the patient away from the respirator toward the goal of absolute independence so that he can be removed to his home for further care. Patients treated here at Wesley are taught to live with their disabilities.

Before a respirator patient is allowed to go home, the relative who is going to do most of the nursing care is requested to spend 24 hours with the patient. The nurses instruct the relative in all phases of this special type of nursing care, including the operation of the respirator, body alignment, feeding, bathing and sanitary measures. Psychological aspects are not neglected, as a proper mental attitude around the home is an important phase of recovery.

ONLY TWO NEED RESPIRATOR

Wesley cooperates with the national foundation in its efforts to group unit patients in keeping with their sex, age and interests. Of the four young women now in one polio ward, only two depend upon the chest respirators for breathing, and they no longer use them all the time. All are "graduates" of the iron lung. One 18 year old girl, a particularly severe case, has been with us for a year and a half, but with the help of all factors in the respirator ward, two others have recovered sufficiently to be returned to their homes.

The usual hospital visiting hours are observed in the ward, and all relatives and friends are requested to leave by 8:30 p.m. so that the polio patients may be prepared for the night. Since all patients are in the stage of recovery, it has not been found necessary to ob-

serve any special restrictions or precautions.

The portable, or "chest," respirator has become increasingly popular for treatment during the last three years. As the incidence of poliomyelitis increases, more room must be made for incoming cases, and as slow as recovery may be, it is definitely made more rapid by the use of the chest respirator. It is now common practice to remove the patient to his home sooner than would be possible were he dependent upon the tank type, or "iron lung." The portable respirator may be used at home if it meets the need of the patient. At present, Wesley maintains four tank type and two of the chest respirators.

It seems that respirator centers are now a trend wherever there is a sufficient number of cases to warrant such a program. A large respirator center is operating in a Baltimore hospital, and one has been set up in San Antonio, Tex. A Chicago hospital has set up a ward for children under 14.

The population in Wesley's respirator ward is changing, an indication that this method of helping to restore breathing function after a dreadful sickness has a tremendous amount of merit. Instead of the afflicted lying in anguished isolation, they are as happy as possible and the greatest boosters for this type of "colonization."

FOOD PURCHASING calls for careful planning

A MODERN HOSPITAL ROUND TABLE

PERIODICALLY, The MODERN HOSPITAL invites several administrators to sit down in our editorial office and discuss their problems. A recording of the conversation is made and the transcript is published here—after editing to eliminate repetition. Hospitals of all sizes and types are represented in these discussions, but the problems selected are those that seem to occur in all kinds of hospitals.

This month, the round table continues its discussion of purchasing and inventory control. Taking part in the discussion are Richard Vanderwarker, administrator of Passavant Memorial Hospital, Chicago (260 beds); Herbert R. Rodde of Highland Park Hospital, Highland Park, Ill. (85 beds), and Mrs. Orpha Daly Mohr, purchasing agent at Wesley Memorial Hospital, Chicago (616 beds). Everett W. Jones, technical adviser to The MODERN HOSPITAL, is moderator.—ED.

MR. JONES: I think we can all agree that under certain conditions certain department heads must be given a lot of leeway in purchasing, even though orders clear through a central purchasing office. Now, let's take such things as staple groceries. How do you handle those in Wesley Hospital? Who buys the groceries?

MRS. MOHR: We have a different organizational setup at Wesley from that of the average hospital. We have a dietary manager who does all the purchasing of food supplies.

MR. JONES: You have Lawrence Nelson as steward, who has complete management of the dietary department.

MRS. MOHR: He is fully responsible for the dietary department—for buying food, keeping costs down, and serving adequate and palatable meals.

MR. JONES: Does he funnel the purchase orders through the purchasing department, or does he issue them direct?

MRS. MOHR: He issues them direct, except for routine supplies for the department, other than food.

MR. JONES: But for all foods he issues the orders and keeps the records?

MRS. MOHR: That's right.

MR. VANDERWARKER: We have the same system as Wesley. The chief dietitian orders all the food, issues the orders directly, and receives and okays the bills.

MR. JONES: How do you handle the inventory of the staples that you buy and put into stock? Who handles the inventory and the issuing of that stock?

MRS. MOHR: At Wesley, the accounting department issues the withdrawals and checks the inventory at the end of the month.

MR. VANDERWARKER: We do the same thing. The storekeeper is an employe of the accounting department, and he is responsible for the inventory and issues requisitions. Then, to control the direct deliveries to the dietary department, we have a weekly food cost report which we use for control of expenditures.

MR. JONES: When you say weekly food cost control, is that set up against some predetermined budgetary cost figure, so you can see whether you're going under or over?

MR. VANDERWARKER: We have a budget figure for food costs which is adjusted with the National Food Index, and the dietary department has to keep approximately within 1 cent per meal in either direction from that figure.

MR. JONES: Do you as the administrator get those regular weekly food reports and take a look to see what they're doing?

MR. VANDERWARKER: I get them every week and look at them very interestedly. That is one of our very important cost control reports.

MR. JONES: Do they issue such reports at Wesley?

MRS. MOHR: We do.

MR. JONES: And both the administrator and the steward in charge of the food department get that report?

MRS. MOHR: They do, and it goes into the monthly operating report and is circulated among the board members as well.

MR. JONES: What controls do you have of your food cost per meal in a smaller hospital like Highland Park?

MR. RODDE: I will have to start at the beginning: About a year ago we were buying our food on a hand-to-mouth basis, with the dietitian doing all the ordering. I changed that system, so that now we buy our staple goods every 30 days. At the first of each month, I have the dietitian prepare a list of wants, and we send that list of wants to five wholesale distributors for prices. They return these lists and the dietitian makes comparisons of price, quality and delivery service. Then she checks the lists and indicates the amounts that she wants. By means of this new system we have eliminated the purchasing of five cans of peas and 10 cans of tomatoes, and we buy everything in case lots.

MR. JONES: I suppose that has materially improved your price situation?

HELPS IN RECEIVING ROOM

MR. RODDE: Very much so. The requests are sent up to my secretary, who types out the orders, and then I sign them and out they go. This has helped in the receiving room also, because all the groceries come in at one time and we can take care of a whole order within a week's time. Each day the dietitian is required to requisition from central stores the amount of staple goods she requires that day. Those requisitions are sent up to me. They're checked out against stock record cards, which are maintained for every item in the supply room, and then sent to accounting. Accounting tabulates them on a monthly basis and then a food cost report is made which is given not only to me but to the board of managers and the dietitian.

MR. JONES: That system requires some preplanning, based on standard menus, doesn't it, to get a rough estimate of how much of each item you want to buy for a 30 day supply?

MR. RODDE: That's another problem our dietitian was having. She would spend countless hours at the end of each day making out tomorrow's menu. I finally suggested that she should make her menus 30 days in advance. I even suggested using the preprinted menus in the journals, but she is the type who prefers to make up her own. On that 30 day preplanning she can now figure out what to buy for a month's supply of food. She does, however, actually make out her menus, at least the basic

Mr. Rodde

Mrs. Mohr

Mr. Jones

Mr. Vanderwarker

elements of the menus, a month in advance.

MR. JONES: Do you make menus up a long time ahead at Passavant?

MR. VANDERWARKER: We have five weekly master menus which are rotated and which contain the basic items. These are reexamined and adjusted according to market conditions and the availability of various items, so that we don't have to go through the chore of completely building a menu every week.

MR. JONES: Those five general master menus are made up by your own people, I suppose?

MR. VANDERWARKER: They are made up by our chief dietitian, in conference with me. We settle certain policies about the price of items we wish to serve in private rooms.

MR. JONES: That's an interesting point—the fact that you as the top administrator have enough interest in your food service to establish the policies which affect the kind of menu you serve to different kinds of patients. I think it would be a good thing if more administrators took more interest in their food service.

MRS. MOHR: At Wesley, Mr. Nelson holds weekly meetings with the chief dietitian and chef and plans menus in advance. Then, by making a slight adjustment to the market, he is able to buy the foods that are best on the market at the time.

MR. JONES: What we're all saying here illustrates that careful planning and thought pay off in purchasing. If all department heads would plan carefully in advance of needs to give the purchasing department warning so it can search out sources of supply and get busy, we'd have more scientific purchasing. But how are you going to handle the dairy products, the meats, the daily perishables?

MR. RODDE: Because of the variability of these nonstaple dietary products, I have left that mostly to the discretion of the dietitian. Many times when she is on the telephone ordering supplies, she finds that a certain item is out of stock and consequently she must make a snap decision on the phone and order a substitute. Unfortunately, we do not have walk-in refrigerators. That is something we are planning now, and we assume when our new construction is completed, we shall have them.

MR. JONES: Why do you need walk-in refrigerators in a small hospital?

MR. RODDE: Under our present system, with a lack of refrigeration space, we are not able to buy the quantities we would like in order to earn quantity prices. For example, we must buy fresh fruit by the pound, not by case, because we do not have the facilities to store that item. We must buy our meat precut and pay a premium price for it, as we lack the facilities to store meats. I think hospitals should buy their meats in quarters and hire a part-time butcher in order to save money. Another problem is our milk, cheese, eggs and butter. We can't buy enough to last a week or so, because of the lack of refrigeration.

ADVANTAGES OF PRECUT MEAT

MR. JONES: Mr. Rodde is advocating buying unprocessed, uncut meat and then having it processed in the hospital, but haven't we seen lately a lot of interesting information on precut, prefabricated meat as an economical method of controlling costs?

MR. VANDERWARKER: I believe from evidence that prefabricated cuts of certain types such as chops and steaks have an advantage. These may add a little to the initial expense, but they have advantage in the control factor. You can buy 15 veal cutlets, and you can be absolutely sure that 15 veal cutlets will be served, and thus prevent waste!

MR. RODDE: But even with prefabricated meats you still need ample storage space, so that you can buy a large quantity when you want to and get a good buy. Isn't that right?

MR. VANDERWARKER: That's true, although the meat market is so variable that it's pretty hard to speculate on it. If you're in a location where you can

get regular deliveries, I think it's probably better not to buy very far ahead.

MR. JONES: When you buy these prefabricated cuts, do you buy one day's supply or a week's supply—how do you handle it?

MR. VANDERWARKER: We usually buy on a day-to-day basis. We know that we're going to serve so many cuts, and we order as many as we need to be delivered the day before their expected use.

MR. JONES: I suppose if you stock up too much meat in prefabricated cuts, these are very handy and convenient to slip in the pocket—and if you had much ahead, you might suffer some loss, wouldn't you?

MRS. MOHR: The dietitian or dietary manager always has to keep that in mind!

NOT THE SOLE SOLUTION

MR. VANDERWARKER: They certainly can walk off with expensive cuts! But I don't want to leave the impression that I think prefabricated cuts are the solution to all meat problems. Certainly, in the ground meat items, the stew items, the items that are cooked by moist heat, and the less tender cuts, it is probably more economical to buy chuck or some other cut and butcher it in your own establishment, and then use the by-products—the bone and the fat—for soup and other items of that type.

MR. JONES: The more we discuss these problems, especially when we get into meats and perishables, the more we can appreciate what a really complicated purchasing problem we're talking about in the food business. Now let's take up a simple problem that I think causes some administrators a big headache—that is, who's going to get the milk and cream contract for the hospital? I don't know that this is a problem in a big city like Chicago, but in a great many towns there is keen competition for the hospital milk and cream contract, because of its prestige value. Dairy people feature in their advertising, "We serve the hospital." That is considered a hallmark of quality.

MR. RODDE: At the present time we do not have a contract, but we are contemplating a contract, inasmuch as prices are always going up. There isn't too much competition for the dairy business, and as a result we split our orders for dairy products among the existing organizations that supply the community.

Readers are invited to write to the editors suggesting topics for discussion at the administrators round table

MR. JONES: Do you think that by concentrating on one supplier, so that he can make one delivery a day of a larger quantity, that you will get a more favorable price?

MR. RODDE: I don't think so, because several of the organizations out where we are specialize on one or two dairy products. Ice cream is one. Actually, we get our ice cream from a corporation in Chicago.

MR. JONES: I can see where a hospital the size of yours would find it hardly pays to make its own ice cream. We hear endless arguments: Should we or shouldn't we make our own ice cream? What do you think?

MR. VANDERWARKER: We purchase our ice cream as a finished product, but I am convinced we could purchase it less expensively by buying the mix and producing it. It's a problem of space, of getting mixer space, hardening cabinets, and so on. At Wesley they make their own ice cream, and I know they make it cheaper than they can buy it.

MRS. MOHR: We make a savings and also we always have ice cream ready to serve the patients and can serve it more frequently.

MR. JONES: You buy the regular mix, though, from the dairies?

MRS. MOHR: We buy the mix from one of the dairies, on contract. May I tell you something of the history of group purchases that Wesley and Passavant have had? We pool our dairy and ice cream demand and we have negotiated contracts annually. Originally when we made that combined contract, by asking for bids from the dairies, we saved a tremendous amount of money. Then the period of rising prices came, and the contract can't protect us from that, because it's based on government prices. But in spite of the rising costs, Mr. Nelson went to work on the contract and made another large saving, which came as a complete surprise to all of us.

MR. JONES: That might indicate that if you could get groups of hospitals in a close area where it is expedient to work together, they could pool their needs in one big contract, and there might be some savings. They're studying that now in Minneapolis. They're thinking seriously of setting up a central purchasing group for standard commodities. I don't think that when you get into special equipment items, and specialty professional items where you need service from individual manufacturers or technical advice, you can do that so well. But on standard food items and certain standard commodities they seem to think such a system will work.

MR. RODDE: I have no experience with centralized purchasing, but I was just wondering—are these groups operating on a drop-shipment basis, or do they do their own warehousing?

MR. JONES: What do you mean by a drop-shipment basis?

MR. RODDE: The purchase orders are pooled and one order is sent to the vendor, with a request that certain portions of it be distributed to the various hospitals.

SAVE 2 CENTS PER PORTION

MR. JONES: That is the way most group plans are operating.

MR. RODDE: To get back to the ice cream for a minute. Several months ago we made a study of the cost of a scoop of ice cream, and we found that we were running about 6 cents a scoop, with a No. 16 scoop. At a hotel convention in Chicago I saw a prefabricated, controlled portion of ice cream, individually wrapped. We found the cost to be 4 cents per portion. Immediately, the dietitian and I instituted the purchase of that particular type of ice cream package, and we have found that we save, on the average, about 2 cents per portion served.

MR. JONES: Of course you're saving, but your patient is getting less ice cream. Maybe that's all right. Did you have any complaints from patients when you gave them this individually wrapped, prefabricated portion?

MR. RODDE: No, the comments were favorable, because the ice cream was being served in a wrapping. They like that very much. The only unfavorable comments that I received were from employes. When you unwrap this ice cream, you get your fingers in it a little bit, and there was a little grumbling about that. Other than that, everyone went along with the quality and the taste.

VISUAL AUTOMATIC FILING *pays for itself*

in increased efficiency with a smaller work force

E. LOUISE SEYMOUR, R.R.L.
Chief Record Librarian
Massachusetts General Hospital
Boston

IRED with enthusiasm after reading about the terminal digit system of filing medical records as described by Dorothy L. Kurtz, R.R.L., of Presbyterian Hospital, New York City,* we immediately made plans to apply this system to our record department.

The principle of the terminal digit method is as follows: numbers, in groups of two figures, are divided into three parts and are read from right to left. The last two digits on the extreme right are called "primary," those to the left of the primary figures are "secondary" and the remaining figures to the extreme left are "final" numbers and are filed in strictly numerical order.

For example: the number 324501 is filed in the "01" primary section, behind the "45" secondary guide. It is then filed in numerical order according to the final numbers—"32." In the drawer it would be between the numbers 314501 and 334501.

Miss Kurtz' success in dividing the file cabinets into sections with the same number of cabinets per clerk intrigued us. It presented all sorts of ideas for increasing efficiency in handling records. Particularly worthy of note is the fact that such a system could make a file clerk's job a specialty rather than a monotony.

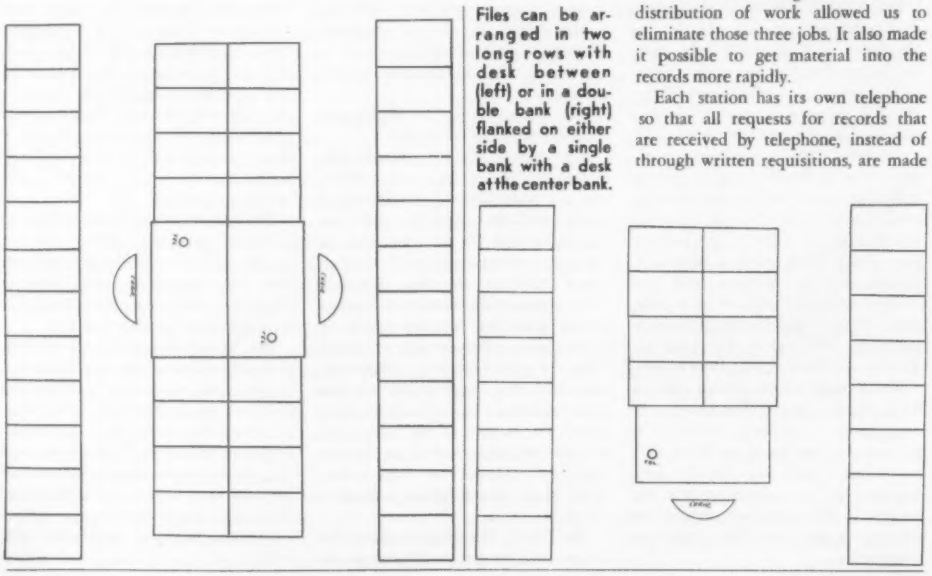
It seemed to us that with proper planning not only pulling and filing but *all* work relative to records, except analysis and cross-indexing of house cases, could be handled by these clerks, *e.g.* the pasting of laboratory and x-ray reports, incorporation of additional sheets, and the like. Production records kept on the various phases of record room work enabled us to determine the amount received and dispatched daily so that an even distribution of the incoming work could be planned.

We therefore divided our 400 file cabinets into 10 groups of 10 terminal digits each, which means 40 cabinets per clerk. As we have 6000 records for each primary digit, four files are required per primary. Each of the 10 groups is called a station (the station number being determined by the next to the last digit) and is handled by one clerk who not only pulls and files records but who also inserts additional sheets, laboratory and x-ray reports, and does other odd jobs.

Time is saved here by not having to make an "out card" for each record pulled for reports, as was done formerly. The clerk, knowing her station, can control these records. Under our former system three persons were required full time to pull and paste reports; they had to take the reports out of the file room to their own working areas. The new distribution of work allowed us to eliminate those three jobs. It also made it possible to get material into the records more rapidly.

Each station has its own telephone so that all requests for records that are received by telephone, instead of through written requisitions, are made

*Kurtz, Dorothy L.: They Run the Record Files Backward. Mod. Hosp. 74:84 (March) 1950.



Files can be arranged in two long rows with desk between (left) or in a double bank (right) flanked on either side by a single bank with a desk at the center bank.

directly to the station instead of going through a central dispatcher. Time also is saved in reporting back to a requester in the event that a record is signed out to another department. Formerly this information had been relayed by the dispatcher. Telephone extension numbers correspond with the station number and digits, as follows:

Records ending in 00 through 09, Station No. 0, Ext. 170.

Records ending in 10 through 19, Station No. 1, Ext. 171, etc.

All requisitions for clinic appointment records and all incoming laboratory reports and the like are received by a dispatcher who sorts them according to the primary digit and delivers them to the proper station. When records for clinic appointments have been pulled, they are given to the dispatcher who bundles them for delivery to the clinics.

The most efficient arrangement of a station is to place the files in two long rows, broken by a space large enough to hold a desk. If two stations can be set up back to back, the clerks can cover each other's telephones.

Or, files can be arranged in a double bank, flanked on either side by a single bank, with the desk placed at one end of the center bank.

Prior to filing, a sorting of the returned records is done in the major category first, which is, in effect, a sorting by station or primary digits. To facilitate identification of records by station, we utilize a strip of colored cellophane tape across the binder edge of the folder at the top left-hand side. (Our records are filed with the binder edge in the upright position.)

As an example:

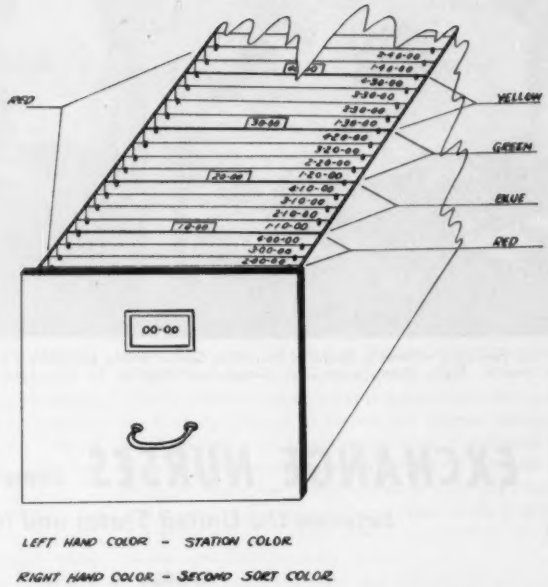
Station No. 0, red
Station No. 1, blue
Station No. 2, green, etc.

This not only saves time but eliminates the possibility of error in the initial sort.

Another, or second, sort is necessary, the secondary digits being utilized, thereby assuring the filing of records in the proper place according to those digits. This second sort is facilitated by use of a different color of cellophane tape placed across the binder edge at the lower left-hand side of the folder:

00 through 09, red
10 through 19, blue
20 through 29, green, etc.

Each station uses the same color for the same secondary digits, thus making all sections uniform except for the primary digit color. Since the primary and secondary sorting colors are placed in different places on the folder, there is no chance of confusing the meaning of the two.



File drawer showing the system of identifying records by various colors.

Investigation proved colored cellophane tape to be cheaper than labels and also provided a greater variety of colors. Now any record misfiled by the primary or secondary digits fairly jumps out of file.

The conversion of 60,000 records from numerical to the terminal digit system of filing took us five months using full-time help in the summer and cutting that to part time when those workers returned to college in the fall. On entirely full-time work, it could have been done in four months or less. The cost of the labor and equipment, *e.g.* guides, telephone extensions, and additional desks, was $5800.

Since our usual expense for work involved in one year's expansion is approximately $2900, the project will have paid for itself in one year, because it has made possible the elimination of three full-time jobs, and it will no longer be necessary to purchase new file cabinets or to move records back to allow for expansion. Inactive records will be removed from the stations and placed in transfer cases in an inactive area.* The number of records that must be removed to allow space for expansion can be determined by the number of new admissions per year.

We found that by using a numbering machine it was cheaper to number the guides ourselves than to have them prepared outside of the hospital. Inasmuch as there is a label on the outside of each drawer, anyway, it was unnecessary to use a guide for the first section of the drawer, thereby saving 2000 guides.

In the actual process of changing systems, we found it easier and more efficient to pull one complete set of digits at a time (00 through 09), make a second sort (00, 01, 02, etc.), and then proceed with filing according to the secondary digits. By this method 10 primary numbers were completed in seven work days as against 10 in 10 days when we processed only one primary digit per day.

After the first five primary digits had been converted, we opened those stations and added the others as they were ready but did not install telephones until all stations were completed. This for us was a trial period and, much to our surprise and pleasure, we found that the problems were minimal.

Left: Elsa Paroja and Wilhelmina Strater of Peru, Ninfa Sardon, Bolivia, and Carolina Garcia, Peru, consult with Wave Arnold, R.N., at Methodist Hospital. Right: Sister Francis Clare, Sacred Heart Hospital, Le Mars, Iowa, and Percida Espinoza and Elsa Diaz from Chile.

EXCHANGE NURSES *cement the ties of friendship between the United States and its South American neighbors*

HAROLD K. WRIGHT
Superintendent
Methodist Hospital, Sioux City, Iowa

THREE years ago I was asked by Dr. and Mrs. Frank S. Beck, medical missionaries in Bolivia, if Methodist Hospital, Sioux City, Iowa, would give some months of experience and training in obstetrics to their obstetrical head nurse, Amalia Ayllon. Having always been intensely interested in the Spanish-American countries and in international friendships in general, I gladly entered into the arrangement. Miss Ayllon spent eight profitable and happy months with us, and we then invited others to come. Neighboring hospitals in Iowa began to inquire as to the possibility of obtaining nurses, and that was the start of a project which grew into quite unexpected proportions.

After finding places for several nurses from Bolivia, I suggested to my friend Dr. V. T. DeVault of the British-American Hospital in Lima, Peru, that some of his nurses might want to have some experience in our hospitals. Dr. DeVault's response was enthusiastic, and after considerable time spent in smoothing out passport requirements nurses began to come from Peru. Some went to the Jennie Edmundson Hospital in Council Bluffs, others to the Clarinda Municipal Hospital, and still others to the Hamilton County Hospital in Webster City. Of this group, two are now employed in the Mayo Clinic, one has married and lives in California, and another is taking postgraduate work in pediatrics in an eastern hospital.

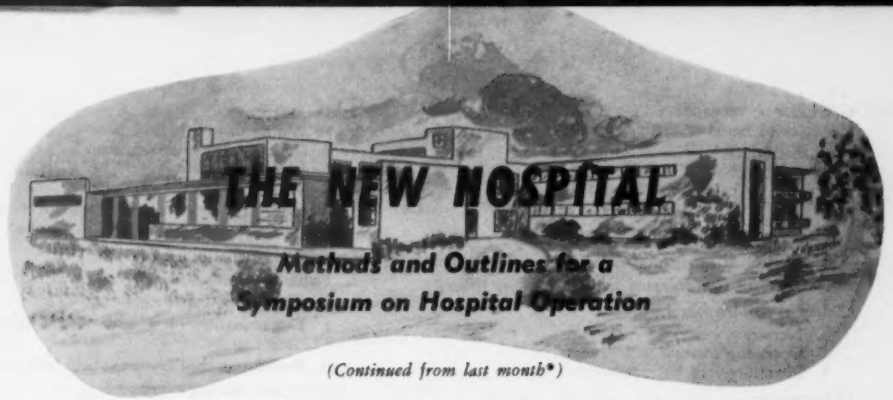
News spreads rapidly, and soon applications began to come from Chile, and I have had the pleasure of placing some 14 nurses from that country. In the meantime, additional groups have come from Bolivia and Peru. Even Argentina heard about it, and two fine young women from Buenos Aires are in the middle of their first year in the hospital in Enid, Okla.

When I use the word "pleasure" I should add that there have been headaches, also. Anticipating that emergencies might arise, and realizing that I had made myself morally responsible to many families in South America for the welfare of their daughters, I began to require the hospitals to make a deposit into a central fund. This enabled me to send some back home who became ill or whose return was required for other reasons, and to adjust some situations where dissatisfaction or misunderstanding crept in. I have scraped the bottom of the barrel now, and in order not to risk bankruptcy I have interested the Rotary Club of Valparaiso, Chile, in sponsoring any other nurses who may come. A group of six nurses is now preparing to leave.

Some serious nurse shortages have been alleviated, at least temporarily, by this project, and in general it has been quite satisfactory to the hospitals. There has been only one case where the nurse has proved unacceptable. Some of the nurses have suffered a mild degree of disappointment in their surroundings, in spite of my efforts to forewarn them that the United States is not all like Hollywood, and that working in a hospital here is no more glamorous than doing the same thing at home.

Some of the girls were amazed to find that some of our hospitals are actually less attractive in buildings and equipment than the hospital from which they came. No serious language difficulties have arisen; on one occasion we were amused to discover that a South American nurse, who had not learned to distinguish between chicken and kitchen had informed a patient that she was having "kitchen for dinner."

For my own part, I hope that the idea will continue to strengthen the ties of friendship between our countries; this hope was greatly encouraged by the many messages of friendliness and appreciation which I received at Christmas time from those who have returned home, as well as from those who are filling posts of usefulness in various parts of our own country.



THE NEW HOSPITAL

Methods and Outlines for a Symposium on Hospital Operation

(Continued from last month)*

THE need for trained hospital administrators has long been apparent in the United States. Of late years the need has become acute. This is due to several reasons.

Advances in medical science and the consequent greater use of hospitals make it more important that those hospitals be operated efficiently. Growth of prepayment hospital plans, as well as universal health consciousness, makes further demands upon our hospitals.

More and better hospitals are needed. And they are being built—both with federal financial aid under the Hill-Burton program and solely with private capital. Many hospitals have been completed and more are under construction. All will need administrators.

To meet the demand for trained personnel, the schools of hospital administration are graduating about 125 potential administrators per year. This number will just about provide for the normal turnover. Further, these university trained people are attracted mainly to positions in the larger institutions. Smaller hospitals must secure their people from other sources. Thus it is plain that additional steps must be taken to provide competent administration for many of the new hospitals.

Being extremely conscious of this tremendous and growing need, the Division of Medical and Hospital Resources has conducted a number of symposiums or institutes designed to give potential administrators a brief but intensive course of instruction. These sessions were designed not to give answers to all questions, but to point out the problems that would arise and where answers might be found. The courses were enthusiastically received.

A number of organizations, state officials and individuals have asked that this material be made available to help them conduct similar courses in their areas. The work of compiling the material has been done by Edward L. Tolson Jr., Hospital Consultant, Division of Medical and Hospital Resources, Public Health Service, Federal Security Agency. —J. R. McGIBONY, *Medical Director, Chief, Division of Medical and Hospital Resources.*

HOUSEKEEPING

I. Qualifications of the executive housekeeper.
   - A. Experience in institutional housekeeping.
   - B. Training and experience in approved methods of cleaning.
   - C. Knowledge of equipment and supplies.
   - D. Ability to supervise the work of others.
   - E. Understanding of the fundamentals of sanitation.

II. Operation of the department.
   - A. Coordination of work schedules with those of other departments.
   - B. Control of supplies.
     1. Establishment of supply centers.
     2. Time of schedule for issue of supplies.
   - C. Inventories and inspections.
     1. Housekeeper maintains room furniture inventories.
     2. Housekeeper reports maintenance defects to the chief engineer.
   - D. Departmental responsibility for development of concise schedule for care of building interior and furniture.
   - E. Selection of cleaning agents.
     1. Care of floors.
     2. Care of walls and windows.
     3. Care of furniture.

III. Good housekeeping is essential to the hospital in its rôle as a community service. Neatness and cleanliness affect all the people who use the hospital and boost employe morale as well. Good housekeeping is part and parcel of good public relations. To accomplish its total purpose, good housekeeping must be carried beyond the lobby. First impressions are important, of course, but it is the lasting impressions of the patients which instill confidence in the hospital. A well-trained, competent housekeeper, able to organize the department into an efficient unit, is the key to economical operation. While the direct budget for housekeeping may be only 3 per cent of the total, other departments are helped to carry out their tasks more efficiently when full value is received for the dollars spent for housekeeping.

LAUNDRY AND LINEN SERVICE

I. Linen management
   - A. Storage requirements
   - B. Control of issue
   - C. Proper marking
   - D. Supply to nursing units
   - E. Supply to other areas
   - F. Employe uniforms
     1. Supply
     2. Control
     3. Cleaning

*The first sections of this outline, dealing with the hospital board and staff, administration, finance, accounting and plant operation, appeared in The Modern Hospital last month. — Ed.

G. Utilization of wornout linens
H. Repair of linens
   1. Facilities
   2. Personnel

II. Laundry management
   A. Linen damage
      1. Control of stains
      2. Control of mechanical damage
   B. Handling of contaminated linens
   C. Special requirement areas
      1. Nursery
      2. Operating rooms
      3. Maternity area
   D. Inspection
      1. Periodic checks on observance of proper washing formulas and wheel loadings
      2. Routine check of volume and temperature of water and steam
   E. Laundering of "nonhospital" work
      1. Personal clothing
      2. Official uniforms

MEDICAL RECORDS

I. Definition[1]: "Sufficient data written in sequence of events to justify the diagnosis and warrant the treatment and end results."

II. Value of the record
   A. To the patient
      1. Serves to avoid unnecessary repetition or omission of treatments and diagnostic measures.
      2. To assist in continuity of care in the event of future illness.
      3. As evidence in event of legal difficulties.
      4. Supplies information required by hospitalization insurance firms.
   B. To the physician
      1. Education of physicians.
      2. Evaluation of practice.
      3. Protection in event of malpractice suits.
      4. Assurance of orderly continuity of care.
   C. To the hospital
      1. Means for evaluation of the proficiency of the individual physician.
      2. Furnishes proof of type and quality of care rendered the individual patient.
      3. Serves to protect the hospital in event of legal difficulties.
      4. Serves as administrative record of personnel performance.
      5. Serves to assist in future program planning.
   D. In medical progress
      1. Recorded observations are the basis for all clinical research.
      2. Group studies of records by the medical staff serve to further the education of physicians and other medical care personnel.
      3. Supply pertinent data for use by public health authorities in control of disease.

III. The medical record librarian
   A. Qualifications
      1. Education
         a. Basic
         b. Specialized training
      2. Personality traits
         a. Ability to work with others
         b. Tact coupled with persistence
         c. Progressive spirit
         d. Accuracy to detail
      3. Eligibility for membership in the American Association of Medical Record Librarians.[2]
   B. Duties and responsibilities
      1. Planning the department (physical facilities).
      2. Organizing the department.
         a. Determination of type of system to be used.
         b. Revision or modification, where indicated, of any existing system.
         c. Assist in development of method to ensure completion of records.
         d. Assist in determination of type and number of reports to be rendered.

IV. The medical records consultant
   A. Utilization in establishing a new department or in "overhauling" the operations in an existing department.
   B. Assistance given to record clerks (those without formal training and with limited experience in the field).
   C. Assistance in training of medical secretaries and typists.
   D. Assistance in compiling records for a medical audit.

Note: Medical record consultants may be qualified librarians in larger hospitals, on the staff of a state agency, or may be independent. Information could be obtained from the American Association of Medical Record Librarians.[2]

V. The medical audit
   A. Purpose of the audit
      To establish that the work of each physician is in conformity with recognized medical practices and that the record of each of his cases indicates, by the end result, that the diagnosis and treatment was warranted (see definition of medical record).
   B. Necessity for medical staff cooperation
      1. Formation of active medical records committee of the staff.
      2. Review of all records by this committee.

VI. Medical nomenclature
   A. Selection of appropriate nomenclature.
   B. Education of physicians in use of selected method.

VII. Content of the record
   A. Records made only by physicians.
   B. Records made by nurses.
      Records made by technicians.
   D. Administrative portions of the record.

VIII. Indexing and filing the record
   A. Types of indexes
      1. Patient index
      2. Physician index
      3. Disease index
      4. Operation index

[1] Huffman, Edna K.: Manual for Medical Record Librarians. Chicago: Physicians Record Co.
[2] American Association of Medical Record Librarians, 116 S. Michigan Avenue, Chicago, Ill.

B. Methods of filing
   1. The serial system
   2. The modified serial system
   3. The unit system

IX. Accessibility of the record
   A. Types of storage cabinets and shelving.
   B. Space requirements in relation to various types of filing systems.
   C. Advantages and disadvantages of microfilming records.
   D. Planned destruction of the medical record.

X. Ethics and the medical record
   A. Status of the record as a "privileged communication."
   B. Status of the record as an "impersonal document."

XI. Summary
   A. Basic principles applicable to medical records
      1. They must be written for all patients.
      2. They must be filed in the hospital.
      3. They must be accessible without delay.
   B. Prerequisites for good records
      1. Adequate space and equipment.
      2. Efficient personnel.
      3. Definite plan for obtaining records.
      4. Supervision.
      5. Sufficient files and cross-indexes.
      6. Periodic reports, usually monthly.
   C. Compliance with recognized standards for maintenance of a medical records department.[3]

CLINICAL LABORATORY

I. Personnel
   A. Classification
      1. Pathologist (part-time or consulting) or physician on medical staff who has some training in clinical pathology.
      2. Registered medical technologist or person with previous laboratory experience. If registered technician is not available, training required depends on the extent of laboratory examinations to be done in hospital.
   B. Responsibilities
      1. Pathologist
         a. Technical guidance and supervision of laboratory personnel.
         b. Performing autopsies and examination of all tissue.
         c. Consultation with medical staff and attendance at staff meetings.
         d. Submission of monthly and annual reports.
      2. Medical technologist
         a. Specific work of the laboratory under supervision of the pathologist or physician appointed head of laboratory.
         b. All specimens received for examination in laboratory.
         c. Prompt examination and return of laboratory report to proper place.
         d. Maintain monthly and annual reports.
         e. Requisition supplies and equipment.
         f. Supervises other personnel in laboratory such as assistants or helpers.
   C. Salaries
      1. Pathologist
         a. Salary
         b. Percentage
         c. Salary and percentage
         d. Fee for service
      2. Medical technologist
         a. Salary

II. Determine type of laboratory examinations to be done
   A. Routine examinations
      1. Examinations which are requested on patients regardless of diagnosis without written order of physician.
         a. Urinalysis
         b. Blood counts and hemoglobin
         c. Blood test for syphilis
      2. Obstetrical patients
         a. Blood Group
         b. Rh factor
      3. Surgical patients
         a. Pathological diagnosis on any organ or tissue removed at operation.
         b. Tonsillectomy.
            (1) Coagulation
            (2) Bleeding time
   B. Other laboratory examinations
      1. Done on written or standing order of attending physician.
      2. Arrangements should be made with near-by larger hospital for handling laboratory examinations not capable of being done by particular hospitals, such as preparation of tissue, complicated bacteriology and blood chemistry tests.

III. Establish procedure for requesting laboratory examinations
   A. Examinations for which nurse or physician would obtain specimen.
   B. Examinations for which the medical technologist would obtain specimen.
   C. Examinations for which apparatus is used by medical technologist at patient's bedside or in special room.
   D. Time schedule for receiving specimens in laboratory.
   E. Emergency requests—someone available to accept emergency requests and have priority over all other requests. Should be kept to minimum and not be overdone.
   F. Procedure for collecting specimens including preparation of specimens, proper container, time for taking specimen (fasting or nonfasting), minimum quantity required to perform test, and time specimen or request for examination should be in the laboratory.

IV. Laboratory forms and reports
   A. Forms
      1. All request-report forms should be uniform size.

[3] See "Essentials of a Registered Hospital," American Medical Association, 535 N. Dearborn Street, Chicago, and "Manual of Hospital Standardization," American College of Surgeons, 40 East Erie Street, Chicago.

2. The number of different kinds of request-report forms kept to minimum. One for each routine examination and miscellaneous one for all others.
3. Use of color to represent different types of examination assists the nurse or physician rapidly to locate report desired.
4. Separate backing sheet for laboratory reports should be provided for patient's medical records.
5. Specimen label and laboratory charge form.

B. Records
1. Reports made in duplicate, one copy kept in laboratory under patient's name, other copy attached to laboratory backing sheet in patient's medical record.
2. Laboratory personnel responsible for sending report back to proper department.
3. Establish responsibility for attaching laboratory report to patient's medical record.
4. Control of reports given to patients.

V. Laboratory charges

A. There are several methods of charging patients for laboratory examinations:
1. Charge for each laboratory examination.
2. Flat rate (regardless of patient's length of stay).
3. A graded flat rate for a limited period.
4. A joint system with a sliding schedule of unit charges.

Practice in surrounding community should be considered in establishing method to be used and fee charged.

X-RAY

I. Personnel

A. Classification
1. Radiologist (part-time or consultant) or physician on medical staff who has some training in the fundamentals of radiology.
2. Registered x-ray technician or person with previous experience in x-ray technic.

B. Responsibilities
1. Radiologist
a. Technical guidance and supervision of laboratory personnel.
b. A radiologist consultant should visit hospital at least weekly and go over the case histories with the physicians in charge of the department.
c. Fluoroscopies should be performed at the time the consultant visits hospital.
d. It is most unsatisfactory to permit technician to manage department and do technical work with physician interpreting his own films.
e. No therapy should be attempted except under the direct supervision of radiologist.
f. Consultation with medical staff and attendance at staff meetings.

2. X-ray technician
a. Specific work of the department under supervision of the radiologist or physician appointed head of the x-ray department.
b. Prompt performance of examination and return of x-ray report to proper place.
c. Maintain monthly and annual reports.
d. Requisition supplies and equipment.
e. Supervise other personnel in department.

C. Salaries
1. Radiologist
a. Salary
b. Percentage
c. Salary and percentage
2. X-ray technician
a. Salary—varies greatly

II. Determine type of x-ray examinations to be done

A. Type of examination
1. Provisions should be available for doing radiographs of bones, chest, spine, abdomen, gall-bladder and skull.
2. Availability of x-ray services to health department.
3. Should therapy be given in small hospital?

III. Establish procedure for requesting x-ray treatment

A. Time schedule for various types of examination.
B. Emergency requests—someone available at all times.
C. Proper preparation of patient.

IV. X-ray forms and reports

A. Forms
1. Request-report—uniform size
2. Backing sheet for patient's medical record
3. Charge slip

B. Records
1. Reports made in duplicate; one copy kept in department under patient's number, other copy attached to x-ray backing sheet in patient's medical record.
2. Diagnosis index file be established.
3. X-ray personnel to be responsible for sending report back to proper department.
4. Establish responsibility for attaching x-ray report to patient's medical record.
5. Control of reports given to patients.
6. Ownership and use of radiographs.

V. X-ray charges

A. Method
1. All charges to patients on fee basis with little variation except in those hospitals where an "all-inclusive" rate system is used. Practice in surrounding community should be considered for basis of fee for different types of examination.

PHARMACY

I. Personnel

A. Arrange for services of a full-time or part-time, legally qualified hospital pharmacist.

II. Administration, supervision and control

A. Administration
1. Establish a drug requisitioning and distributing system for departments served by the pharmacy.
2. Develop an approved, uniform schedule of charges for drugs.
3. Coordinate its services with the business office in purchasing and pricing of charges and credits.

B. Supervision and control
1. Drug stocks in nursing units inspected at least monthly for:

a. Outdated and deteriorated drugs.
b. Condition of containers and labels.
c. Excess stock.

2. Standardize drug stocks on nursing units and other areas.
3. Maintain stock of drugs for emergencies and antidotes in approved areas.
4. Specifications for purchase and storage of all medications used in treatment of patients.
5. Perpetual inventory of narcotics and alcohol which records the quantities dispensed and received.

III. Records and reports

A. Records

1. Requisitions from other departments.
2. Prescription files.
3. Narcotic and alcohol records.
4. Purchasing records.

B. Reports

1. Monthly and annual report.
   a. Financial: inventory, income and expenses.
   b. Statement of accomplishments and activities — number of prescriptions filled, number of nursing unit baskets filled, report of manufacturing.
   c. Suggestions and recommendations for improvement.

IV. Drug policy

A. Physicians, representing the medical services, collaborating with the pharmacist should comprise the pharmacy or therapeutics committee. This committee establishes and maintains the drug policy for the hospital, and determines what drugs are most useful and economical to carry in stock.

B. Selected medications are then developed into a hospital formulary; curtails expensive inventories. The drugs to be kept in the nursing units and elsewhere should be enumerated by the committee as well as the "ordinary drugs" to be dispensed without charge to patients.

NURSING SERVICE

I. General pattern of nursing service

A. One pattern for all hospitals is impractical by reason of variance in needs and purposes of individual establishments.

B. To be safe, effective and economical, nursing service in a given hospital must be designed specifically for that institution.

II. Needs and requirements (policies, practices and personnel) of the nursing services will be dependent upon:

A. Purposes of the nursing services.

1. Quality and quantity of nursing care to be given.
2. Education and training programs to be offered.
   a. Formal (undergraduate, graduate, professional, nonprofessional)
   b. In-service (professional, nonprofessional)
3. Research (nursing, other associated)

B. Number and type of patients to be cared for (including acuity and length of stay).

C. Over-all administrative framework and practices.

1. Degree and nature of delegation of responsibility.
2. Budgetary practices.
3. Type and character of interdepartmental and intradepartmental relationships.
4. Employment policies.
5. Other.

D. Local medical practices.

1. Over-all medical care practices in effect, such as: rooming-in, early ambulation, natural childbirth, home care, degree of utilizing community health agencies, surgical practices, research, others.
2. Medical education programs.
3. Medical research.

E. Physical facilities and resources available.

F. Type and number of personnel employed.

G. Professional relationships.

1. Cooperativeness.
2. Team practices.
3. Establishment of common goals.

Staffing

I. Scope of the problem.

A. Nursing personnel comprise largest single group of hospital personnel.

1. Account for about one half of hospital salary costs.
2. In one study[4] nursing personnel comprised average of 57% of all personnel (range 54-60%).

B. Category classifications vary among institutions (aides, maids, attendants).

C. Increase in practice of employing several kinds of nursing personnel (professional, nonprofessional).

D. Variation in organizational plans among hospitals.

1. Over-all administrative.
2. Within nursing department.
3. Interdepartmental.
4. Interagency.

E. Competition for nursing services.

1. Increased number of employers of nurses.
2. In 1949 hospitals and institutions employed 47.2% of all nurses.[5]

II. Classification of nursing personnel.

A. By professional or nonprofessional status.

1. Professional (graduate registered nurses and professional students).
2. Nonprofessional (practical nurses, practical nurse students, orderlies, attendants).

B. By preparation (or training) previous to time of employment or by training on the job only.

1. Preemployment trained.

   These are employed on the basis of previous planned program of preparation which has prepared them for specific responsibilities and duties. Although in-service training programs may be offered for them, such programs are not essential to initial delegation of responsibilities or duties.

[4] Schafer, Margaret K.: Staffing the General Hospital—25 to 100 Beds, Federal Security Agency, Public Health Service, 1949.
[5] "1949 Facts about Nursing," American Nurses' Association.

a. Graduate registered nurse.
b. Graduate practical nurse.
c. Trained graduate attendants (*i.e.* psychiatric, infant).

2. In-service trained. This includes personnel employed with no formal preparation for their duties but who are trained on the job for specific functions to be performed.
EXAMPLE: Aides, attendants, ward helpers, orderlies.

C. By assignment
1. Administrative—supervisory—head nurse
a. Director of service
b. Bedside units (patient areas)
c. Nonbedside units (O.R.)
2. Staff
a. Bedside units (patient areas)
b. Nonbedside units (O.P.D., O.R.)

III. Factors which affect staffing.
A. Size of hospital
1. Total beds
2. Bassinets
3. Operating suite
4. Delivery—labor suite
5. Emergency department
6. Outpatient department
7. Clinical services
8. Other
B. Physical facilities
1. Arrangement
2. Conveniences
3. Safety
4. Other
C. Supplies and Equipment
1. Adequate amount
2. Maintenance and repair
3. Convenience
4. Availability
5. Other
D. Number and type of patients
1. Degree of illness
2. Length of stay
3. Segregation
4. Type of illness
5. Other
E. Medical practices
1. Types and frequency of treatments ordered
2. Educational or research programs
3. Other
F. Standards of nursing care
G. Schedule of operations
H. Number and kinds of emergencies received
I. Number of deliveries
1. Length of stay
2. Rooming-in
3. Other
J. Number and type of outpatients treated
K. Education and research
L. Personnel employed
1. Qualifications requirements
2. Experience requirements
3. Training policies
M. Functional organization pattern of the hospital

IV. Staffing guides
A. Major sources, in order of recency
1. "Hospital Nursing Service Manual," American Hospital Association and National League of Nursing Education, 1950.
2. "A Study of Staffing the Small General Hospital—Less than 100 Beds," Federal Security Agency, Public Health Service, 1950.
3. "Staffing the General Hospital—25 to 100 Beds," Federal Security Agency, Public Health Service, 1949.
4. "A Study of Nursing Service in One Children's and Twenty-one General Hospitals," National League of Nursing Education, 1948.
5. "Manual of Essentials of Good Hospital Nursing Service," American Hospital Association and National League of Nursing Education, 1945.
B. Use of guides
1. General guides only.
2. Must be adapted to each specific situation.
3. When needs are computed only on basis of hours-of-care-per-patient formula, net results are for bedside staff only.

V. Staffing the nursing department in the new hospital
A. For preparation to open the hospital.
1. Selection of key personnel (such as director, operating room supervisor, obstetrics and medical-surgical head nurses).
2. Employment date dependent upon
a. Completion of construction.
b. Arrival of equipment and supply.
c. Organizational plan.
B. For initial operation.
1. Provide 24 hour coverage for all nursing areas for anticipated initial patients.
2. Number, type and employment date dependent upon
a. Previous progress in preparation to open hospital.
b. Anticipated patient load.
c. Hospital medical care program.
d. Established employment policies.
C. For optimal operation.
1. Provide 24 hour coverage for all nursing areas for "normal" hospital operation.
2. Planned expansion of initial staff to meet growing utilization of hospital.
3. Numbers, type and employment date dependent upon
a. Hospital utilization.
b. Operational standards and policies.

Establishing the Nursing Service in a New Hospital

General Comment

The following is presented as one approach by which the nursing director can systematically prepare for nursing services in the new hospital. It is essential that she work closely with the administrator and other proper authorities throughout such preparation.

In order to assure sound planning for all phases here described the director of nursing service should be employed from four to five months prior to the opening date. Time elements given for each step and the steps themselves will dovetail.

I. Self-orientation to: (time required, 1 month)
A. Administrator, board, medical staff and others employed at this time.
1. Orientation to their plans, philosophies, and so on.
2. Present and interpret proposed nursing services to them.

B. Basic pattern of hospital operation.
   1. Administrative framework.
   2. Local medical practices.
   3. Type of patients to be cared for.
   4. Initial policies (especially employment).

C. Physical facilities and equipment (general overall orientation only).

D. Community resources.
   1. Other health agencies and hospitals.
   2. Referral systems.
   3. Civic and professional groups and organizations (official and voluntary, police, clubs, associations).
   4. Housing (potential for personnel).
   5. Voluntary (auxiliary) resources.
   6. Potential employes and sources of them.
   7. Refresher courses available.

E. State maintenance and operation laws and regulations under which the hospital will qualify and which will influence the nursing service.

II. Preparation of basic staffing pattern for nursing services (time required, 1 week).
   A. Number, kinds, qualifications, duties of personnel (by departments).
   B. Budget (preparation, review and adjustment).
   C. Obtain administrative approval.

III. Begin procurement of personnel (time required, 1 to 2 weeks)
   A. Sources:
      1. Professional organizations.
      2. A.N.A. placement and counseling bureau, state nurses' association, local registries.
      3. Commercial agencies.
      4. Schools of nursing.
      5. Other hospitals for referrals.
      6. Personal acquaintances.
   B. Methods used to obtain nursing personnel (professional and nonprofessional, full-time and part-time).
      1. Applications, direct.
      2. Letters, direct.
      3. Public relations programs and communications.
         a. Local publications.
         b. Farm journals.
         c. Professional magazines.
         d. Local community centers.
         e. Local broadcasting station.
         f. The hospital's brochure.
         g. Churches.
      4. Scouting: direct contact appeal.
         a. Civic and other local organizations, such as:
            (1) Kiwanis Club, Elks Club, American Legion Post, Parent-Teachers Association, Granges, Business and Professional Women's Club, Red Cross chapter, Junior League, women's auxiliary, Girl Scouts, 4-H clubs, Y.W.C.A. and Y.M.C.A., high schools and colleges.
            (2) Professional groups or individuals, *i.e.* physicians, dentists, nurses, especially directors of nursing schools and nursing services.
            (3) Prospective applicants.
   C. Salary references.
      1. "Hospital Salary Survey—1949"—American Hospital Association.
      2. "1949 Facts about Nursing"—American Nurses' Association.
      3. Policies and practices statements—state nurses' associations.
      4. State placement and counseling office.
      5. District nurses' association.
      6. Official nurse registries.
      7. Hospital council.
      8. Individual hospitals.

IV. Analysis of professional equipment and supply (time required, 1 week).
   A. Type, adequacy and amount.
   B. Essentials on hand or on order.

V. Preparation of basic nursing organization plan (time required, 1 week).
   A. Based upon total hospital plan.
   B. Obtain administrative acceptance.
   C. Expand later with staff.

VI. Preparation of basic nursing service policies, in writing (time required, 2 weeks).
   A. Purpose.
      1. For control.
      2. For safety.
      3. For economy.
   B. To be further developed later with nursing staff.
   C. Based upon total hospital plan and medical practices.
   D. Includes policies for
      1. Employment, health and welfare.
      2. Patient care.
         a. Protection to patient, family, hospital, physician and nursing staff.
         b. Placement of duties and responsibilities.
         c. Controls for equipment and supply.
         d. Private practice nurses.
         e. Standing orders.
         f. Early ambulation, rooming-in.
      3. Safety.
         a. Control of narcotics, hypnotics, poisons, radioactive substances (against loss, theft, abuse).
         b. Medication brought to hospital by patient and visitors.
         c. Senile, irrational, irresponsible patient (side rails, restraints).
         d. Oxygen therapy (cigarets, candles).
         e. Patients transported from one department to another.
         f. Control of hospital incurred infections.
         g. Fire alarm, disaster procedures.
         h. Effectiveness of sterilization methods and aseptic technic.
         i. Other.
      4. Economy.
         a. Use of equipment and supplies.
         b. Selection, training and assignment of personnel.
   E. To become a part of the total hospital manual.
   F. Obtain administrative acceptance.

VII. Select basic nursing procedures (time required, 2 weeks).
   A. Procedure manual.
   B. Adjustment to
      1. Medical-nursing practices.
      2. Equipment on hand.
      3. Recommendations of nursing staff (continuous).
   C. To be adopted as part of hospital manuals.

VIII. Establish nursing records in keeping with those for entire institution (time required, 1 week).
- A. Administrative.
- B. Interdepartmental.
- C. Personnel.
- D. Patients (nursing records).

IX. Assignment and orientation of initial nursing personnel (time required, 2 weeks).
- A. Staff for preparation to open.
- B. Staff for minimal operation.
- C. Includes
  1. Establishment of regular conference periods.
  2. Orientation.
     - a. To plant.
     - b. To policies and practices.
     - c. To organization.
     - d. To duties and responsibilities.
     - e. To procedures.

X. Supervision of preparation and distribution of equipment and supply (time required, 2 weeks).

ADMITTING

I. Definition

The admitting procedure is the channel through which the patient becomes the guest of the hospital. As such, it usually is the first point of actual contact with the patient and has therefore a tremendous public relations possibility and responsibility.

II. Functions
- A. Supply information to prospective patients.
- B. Make reservations and appointments.
- C. Interview patients and obtain such necessary information as:
  1. Identifying data.
  2. Social data.
  3. Accommodation and rate determinations.
- D. Preparation of necessary forms.
- E. Room assignment.
- F. Send information to nursing unit in advance of patient arrival.
- G. Arrange for protection of patient's valuables.
- H. Arrange for patient payment.
- I. Arrange for discharge notices to and from departments concerned.
- J. Other functions which may be assigned in whole or in part to admitting.
  1. Obtaining consent to operate.
  2. Registration of newborn infants.
  3. Arrange for postmortems.
  4. Arrange for release of bodies to undertakers.

III. Administrative aspects
- A. Designate personnel responsibile for admitting patients.
  1. Large hospital—authority may be vested in single individual or departmentalized.
  2. Small hospital—responsibility usually delegated to several people (bookkeeper, nurse, administrator).
     - a. Routine tasks and execution of forms may be done by bookkeeper or nurse.
     - b. Final decision as to admissibility, rate fixing, credit and allowances are usually made by the administrator.
- B. Provide for 24 hour coverage, seven days a week.

C. Provide attractive surroundings and privacy.
   1. Patients' first impressions of the hospital are affected by physical surroundings as well as personnel of the admitting office.
   2. The patient prefers interview in privacy rather than across counter where he or she can be overheard by visitors, patients or others waiting to be admitted.

D. Establish definite procedure for admissions and discharge.
   1. Where responsibility is divided ,all concerned should know exactly what to do.
   2. To ensure complete information.
   3. To control release of information.

E. Establish policies and procedures governing emergency outpatients.
   1. Admission and discharge.
   2. Care of patients who have no physician.

F. Coordinate admitting and discharge procedures with other departmental routine.
   1. Bookkeeping.
   2. Credit and collections.
   3. Charges.
   4. Discharge of patients.

FOOD SERVICE

I. Objectives
   A. Satisfaction to the patients—
      By serving attractive, palatable meals which they will enjoy.
   B. Satisfaction to the physicians—
      By serving nutritious, wholesome meals which will assist them in getting their patients well.
   C. Satisfaction to the hospital administration—
      By serving "reputation-building" meals as economically and efficiently as possible.

II. Factors affecting the achievement of the objectives
   A. Layout of the physical equipment.
   B. Personnel.
   C. Food.
   D. Control.

III. Establishing the food service
   A. Layout of equipment.
      1. Initially, a drawing board problem, the solution of which involves competent consultation in planning for efficient utilization of space and determining type of service.
      2. Present problem is efficient utilization of space provided and the type of service which has been determined.
   B. Personnel.
      1. The department head.
         a. Trained full-time hospital dietitian.
         b. Interhospital coordination — part-time traveling administrative department head supervising more than one institutional dietary service.
         c. Capable individual trained in some related field who with help from a dietetic consultant can be trained on the job to assume responsibility as the head of the department.
      2. Department staff.
         a. Factors which determine the number and type—
            (1) Single or multiple story building.
            (2) Variety of distribution system.

(3) Type of patient.
(4) Local practices and procedures.

b. Employes.
(1) Chef or head cook.
(2) Other cooks.
(3) Food preparation people.
(4) Assembly and distribution people.
(5) Dishwashing and clean-up people.

C. Food.
1. What to buy—
a. Depends on ability of the department head to plan meals and ability of the cook to produce them.
2. Where to buy—
a. Local merchants.
b. Nearest supply center.
c. National distributors.
3. Who will buy—
a. Staples.
b. Perishables.
4. How to buy—
a. Specifications.
b. Seasonal purchasing.
5. How much to buy—
Influenced by factors
a. Type of ownership and management.
b. Buying power of the institution.
c. Type of buying organization.
d. Receiving and storage facilities.
e. Proximity to source of supply.

D. Adequate system of food control.
1. Purchase.
2. Receipt and storage.
3. Issuance.
4. Preparation.
5. Service.
6. Quality and nutritional aspects.

IV. Making the food service work.

A. Delegate responsibility and authority to qualified department head.

B. Establish policies and procedures to assure efficiency and interdepartmental cooperation.

C. Train personnel with on-the-job programs.
1. Philosophy of hospital dietetics.
2. Sanitation and personal hygiene.*
3. Food preparation and serving technics
4. Safety.

SAFETY

I. General safety

A. The hospital safety committee.
1. Duties.
a. Periodic inspections of premises.
b. Maintenance of safety reports.
2. Members.
a. Administrative representation.
b. Medical and nursing staff representation.

B. Inspections.
1. By outside agencies.
a. Fire department (local).
b. State fire marshal.
c. Local or state safety councils.
d. Insurance company engineers.
2. By hospital safety committee.
3. Responsibilities of each department head.

C. Specific duties and responsibilities of the chief engineer.
1. Safety and building maintenance.
2. Safety and equipment maintenance.
3. Safety and grounds maintenance.

D. Marking (and maintenance) of exits, exit lights, stairways, steps, ramps and fire escapes.

E. Prevention of falls by patients, visitors and employes.
1. Use of bedside rails.
2. Cleaning and waxing of floors.
3. Adequate illumination.
4. Transport of patients.

F. Use of mechanical restraints on patients.
1. Medical staff instructions.
2. Legal aspects.
3. Supervision.

II. Fire safety

A. Fire prevention.
1. Employe education.
2. Building maintenance.
3. Importance of good housekeeping.
4. Fire detection systems.
5. Sprinkler systems.
6. Fire watchman.

B. Fire fighting.
1. The hospital fire brigade.
2. "First aid" fire equipment.
3. Automatic sprinklers and standpipes.
4. Written fire fighting instructions.

C. Evacuation of patients.
1. Specific, written program.
2. Training of employes.

III. Summary and remarks:

In the light of certain tragic experiences within recent years, many hospital people have come to associate safety with catastrophe prevention. While this is, of course, of great importance, it still remains that total safety programs must not be ignored.

The fundamental responsibility for maintenance of safety rests with the governing board. However, that of the administrator is only slightly less, both morally and legally. Under the administrator some major department head, such as the chief engineer, may be delegated a considerable amount of responsibility. In any case such a person must possess the ability to influence all other personnel if the total safety program is to succeed.

The fire prevention program should be a part of the general safety program, for a well-planned attack on the causes of fire closely parallels similar attacks on the causes of personal injury.

Strong administration is essential.

The following national organizations can provide excellent assistance or advice (including manuals, guides, posters) on fire safety and general safety:

1. National Fire Protection Association, 60 Batterymarch Street, Boston 10.
2. National Safety Council, 20 North Wacker Drive, Chicago 6.
3. National Board of Fire Underwriters, 85 John Street, New York 7.
4. Local or state safety councils.
5. The American Hospital Association, 18 East Division Street, Chicago 10.
6. The various insurance companies.

Note: The Hospital Safety Service which is produced by the National Safety Council and sponsored by the American Hospital Association offers much information to assist hospitals in the development of adequate safety programs.

* Most municipal health departments sponsor programs of value to food handlers. These are excellent sources of assistance in this phase of employe training.

PUBLIC RELATIONS

I. What are public relations?

"A cooperative plan of utilizing every possible legitimate and ethical means of (1) informing the public of the benefit it can expect to derive from its hospital, and (2) fostering genuine good will towards the hospital through an understanding and appreciation of the services that the hospital offers to humanity." (American Hospital Association)

II. Why does the hospital need good public relations?

A. The hospital (building, staff, services) as a public service organization
   1. Constant, critical scrutiny by
      a. Community
      b. Patient, his family, and his friends
      c. Staff
      d. Employes

III. What can be gained through spread of knowledge?

A. The hospital
   1. Prevention of misinformation
   2. Better understanding by the public regarding
      a. The hospital's rôle in case of indigent patients, especially problem of payment.
      b. The need for adequate and up-to-date plant and equipment.
      c. Personnel problems, including staffing and need for community assistance in attracting personnel.
      d. Continuous readiness-to-serve aspect of hospital.
      e. Hospital's contribution to community employment, economics and health.

B. The patient
   1. Understands that
      a. service is adequate in quality
      b. service is pleasant, efficient and effective
   2. Assurance that cost of service is as low as feasible

C. The community
   1. Understanding of current hospital activities, problems and progress.
   2. Assurance that the hospital's services will be there when needed.

IV. Components of good hospital public relations

A. The patient, his family and friends

B. Professional staff and other employees

C. Community organizations

D. Public information media
   1. Press
   2. Radio and television
      a. Information *v.* publicity

V. Responsibilities for good hospital public relations:

A. The Board

B. The Administration

C. The Employe

D. The Staff

COORDINATION

I. Goal—"Better Patient Care."

II. Concept

Through regionalization, it is hoped that the medical school and the teaching center can, in effect, grow out horizontally so that the campus of the medical school is extended to the entire region or to an entire state.

III. Definition

A technic which provides, through cooperation, an integration of the mechanics of operation and an exchange of knowledge which helps improve and make more effective clinical services, educational opportunities, and administration—all of which adds up to better patient care.

IV. Present situation

A. Report of Commission on Hospital Care
   1. Hospital system today, because of the diversity of background objectives of sponsoring interest, has resulted in widely differing patterns of organization, administration and control.
   2. Very little coordination—in some instances competition.
   3. Disorganized, unrelated and oftentimes overlapping patterns of hospital care.
   4. Critics describe it as uneconomic and ineffective.
   5. Patrons admit there is room for improvement.

B. Hospital Survey and Construction Program
   1. State plans—divide state into hospital service areas and regions.
   2. This regionalization or coordination exists only on paper.

C. Existing plans
   1. Council of Rochester Regional Hospitals—New York.
   2. Bingham Associates Fund—New England.
   3. Medical College of Virginia—Virginia.
   4. The Duke Endowment—Carolinas.
   5. Kellogg Foundation—Michigan.
   6. Cleveland Hospital Council—Cleveland.

V. Program

A. Clinical services
   1. General diagnostic facilities and services.
   2. Clinical consultation—pathology, laboratory, radiology, cardiology, premature infants, and general.
   3. Pharmaceutical services.
   4. Nursing activities.
   5. Public health.
   6. Prevention of communicable disease.

B. Administrative services
   1. Administration—uniform accounting, central purchasing, insurance, and joint fund raising, central employment guidance.
   2. Hospital finance.
   3. Personnel and staffing requirements.
   4. Dietary services.
   5. Plant operation.
   6. Equipment and supplies.
   7. Building design and construction.

C. Educational services
   1. Assignment of interns or residents on a rotating basis to community hospitals.
   2. Clinical conferences.
   3. Continuation courses.
   4. Training, leading to specialization.
   5. Medical records.
   6. Nursing education.
   7. Training of administrators.
   8. Hospital licensure.
   9. Health education.
   10. Technical or other professional training.

CHARGE TICKET *presents the evidence that enables Connecticut hospitals to recover full costs for service*

HIRAM SIBLEY
Executive Director
Connecticut Hospital Association
New Haven, Conn.

IF ONLY hospitals were business-like in their management! If only hospitals could produce reliable information on income and costs!"

How many times these statements have been thrown at hospitals when they have attempted to negotiate increased rates of reimbursement with Blue Cross, insurance companies, welfare departments, and other third party contractual groups! In 1948 Connecticut hospitals received a per diem rate of only $5 for indigent patients. When application was made to the state department of welfare for adjustment of this rate, it was met by these challenging statements. At that time Connecticut hospitals agreed that never again would they let these challenges go unanswered. Unanimously they agreed to undertake a program of uniform accounting and reporting in order to substantiate their claim that the state's payment was far below the actual cost of care given. Such a step was logical once the resistance to joint action and majority decision had been overcome. The happy result of this united effort is that the state now reimburses each hospital on an actual cost per individual patient, provided the hospital can substantiate such cost.

MAJORITY OF SERVICE

Because "third party" contractual groups—Blue Cross, Workmen's Compensation, state and city welfare, and other agencies purchasing hospital service in bulk—represent the majority of hospital service rendered to patients, they become the most important present-day source of hospital income. Consequently, it is vital to the hospitals' continued existence that their reimbursement represent at least a recovery of the cost of services rendered. It is the establishment of that cost with which we are now concerned.

Cost analysis is largely a matter of fractions or percentages. The numerator is invariably a financial figure, the denominator a hospital statistic. One example is the inpatient per diem cost obtained by dividing inpatient expense by total patient days. Another is the cost per meal obtained by dividing total expense of the dietary department by total meals eaten. Such simplification serves to put the problem in its proper balance. Hospital accounting departments, therefore, are required not only to produce accurate general ledger figures, but, equally important, to develop accurate departmental statistics. While much attention has been given to the hospital general ledger or chart of accounts, far less has been given to the development of simple but accurate methods of keeping track of laboratory tests, x-ray films, hours of anesthesia, prescriptions filled, or sterile supplies requisitioned. Yet these are only a few of the departmental statistics which must be compiled accurately if expense is to be allocated properly to other hospital departments or if a proper division of expense is to be made between inpatient and outpatient cases.

The Connecticut hospitals in 1948 were fortunate in two particulars: first, they were blessed with a hard working committee of hospital accountants who were willing to set aside personal preferences if the majority of the hospitals were to benefit, and second, the chairman of the committee was Edwin R. Johns, controller of the Grace-New Haven Community Hospital. Mr. Johns' hospital had long been aware of the need for accurate statistical information. After several years of experimentation it adopted a charge ticket which served primarily as a source of entry on patients' accounts, but which at the same time provided a means of gathering accurate statistical data.

Connecticut has 34 general hospitals, ranging in size from more than 800 beds to fewer than 40 beds. These hospitals are situated in 26 cities and towns. The largest concentration of hospitals in one city is in Hartford, where there are four general hospitals. Eight of Connecticut's hospitals have more than 300 beds; 12 have fewer than 100 beds. Several general hospitals have facilities for the most complicated surgery, while at the other end of the scale one or two of the general hospitals have not yet qualified under the standardization program of the American College of Surgeons. Local custom requires that local accounting firms audit hospital accounts, while several of the hospitals have been satisfied to have a partial audit made annually by a member of the board or an officer from the local bank.

Such a variety of circumstances added to the challenge which faced the committee. There was also reluctance in all of the hospitals to increase expenses in the accounting office. What, then, were the choices forced on the committee?

First, better use must be made of available facilities. Second, improved systems had to be developed, flexible enough to meet both the complex problems in a large hospital and the individual situation of the small hospital without placing a heavy burden of labor or expense.

THREE MAJOR DIVISIONS

The committee agreed to recognize three major divisions of operating expense: (1) routine service, which was defined as room, board, general nursing care, and routine medication; (2) special services, such as operating room, delivery room, anesthesia, radiology, pharmacy, laboratory, oxygen therapy, and (3) outpatient service, which included clinics, ambulatory service and emergency room. In turn, routine service in the larger hospitals was divided into four classes of accommodation: private, semiprivate, private ward and staff ward. No division of routine service expense would be made in the smaller or one-class-of-accommodation hospitals where the floor nurse gives care to patients in all ranges of accommodation. In all hospitals it was agreed that no division

Left: Edwin Johns, controller of Grace-New Haven Hospital, studies some statistical reports. Center: Data for reports are quickly sorted from requisition cards. Right: The requisition is created at the nursing stations.

of expense would be made by accommodation for the special services, as the ward and private patient receive comparable care in the operating room, and service in the laboratory or pharmacy.

Study of hospital charges indicated that an average of three charges originated daily per patient in the special service departments. In addition, it was realized that while personnel working in these departments recognized the need for preparing charges, they often could not be persuaded to keep accurate track of the number of tests performed, or other services in terms of measurable units. The committee argued: "Could not statistics for special service departments be shown on the charge ticket and compiled in the accounting office?"

How could this be done without adding to the detail already handled by the accounting office and without increasing expense? The major problem, it was recognized, was the repeated sorting of charge tickets by class of patient, paying agency, and special service department. In all but the smallest hospital hand sorting would be an expensive process. The committee turned to its chairman for guidance.

Mr. Johns recommended that the committee investigate a mechanical sorting method. Careful examination disclosed that the method is simple but effective; and the committee was amazed by the wealth of detailed information which could be made available not only for cost analysis and statistical studies but also for good administration. What of the factor of expense? It was demonstrated that the system was economical not only in the cost of the charge ticket but also in clerical expense. Furthermore, the system lent itself to standardized design of the charge ticket which afforded additional economy to the hospitals of Connecticut through group purchasing.

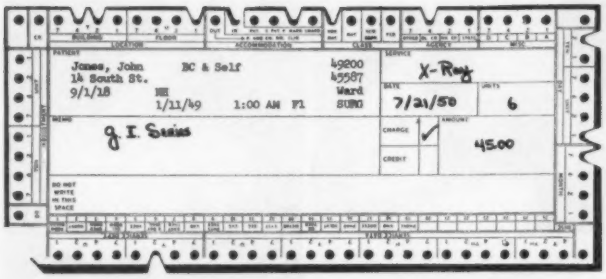
The charge ticket differs from any other only in the holes around the margin which make sorting of various factors simple. Two kinds of codes can be and are used—the direct and numerical. The direct code is used where there are only a few classifications, such as type of patient, and will serve to explain how the card makes possible easy sorting of desired factors. If the charge ticket is being used for a private room patient, the card is slotted at the hole which reads "Private." An instrument, much like a conductor's punch, makes a V-like slot at that point. In sorting, a tumbler is inserted through a stack of cards at the hole marked "Private" and lifted. The notched cards, not being supported on the tumbler, drop out; and in one easy operation private patients are separated from the rest.

Any desired classification can be coded by slotting the marginal fields in the card, either by the direct code or by assigning a numerical reference to the classification. With this device, therefore, service charges performed by the various special service departments can be analyzed by sorting and resorting the same medium. The important thing is that the original source document is the means of analyzing these charges.

In presenting a new method or routine for obtaining much needed information, the committee considered it highly essential that no change, or as little change as possible, be made in present methods of charging patients. If the proper method were adopted and routines were flexible enough, the nursing floor and service department routines would not be disturbed. Many member hospitals were following procedures for charging patients of which they were proud; and by adhering to this attitude, the committee did not incur the disfavor which inherently follows new methods. Following this precept, the committee adopted a standard charge ticket and recommended it to the association.

In May 1950, the Norwalk Hospital brought matters to a head by ordering an annual supply of charge tickets. Suddenly this precipitated a flood of orders, and within 30 days 24 hospitals had committed themselves to the standard plan. There followed six months of installations. When a hospital telephoned to say that its charge tickets had arrived, an installation visit was immediately scheduled. The installation team included the accounting consultant on the staff of the Connecticut Hospital Association, Bernard L. Felton, and supervisors trained for installation of the mechanical card system. Ordinarily, two days were required for a complete installation. When the forms and procedures were installed, a manual was written for the hospital, tailored to fit its particular procedure. The manual indicated where the charge ticket should originate, how it was to travel through the hospital, when it was to be punched and by whom, at what point a sort was to be made, and how the statistical information would be recorded.

For example, at the Grace-New Haven Community Hospital, the charge ticket is created at nursing stations where there is an addressograph plate for each patient. When a requisition



Charge ticket serves to enter charges and provide basic statistics.

for service is made, the nurse imprints the requisition for service and a charge ticket with the patient's plate, carrying name and address, nursing unit, accommodation, class of payment, and professional service, such as surgery, maternity and so on. Space is provided on the charge ticket for entry of a description of the hospital service, units of service rendered, and the charge. The ticket accompanies the requisition to the special service department, where notation is made of the service performed.

SYSTEM WORKS EFFECTIVELY

Many Connecticut hospitals do not originate charge tickets at nursing stations, are not equipped with addressograph machines, and do not care to analyze service charges by nursing station. In the majority of hospitals the special service department makes the original report to the business office. For all these members the system works as effectively as it does for Grace-New Haven. The committee simply adapted the mechanical charge ticket to each hospital's routine; actually it is only a substitution of one kind of charge slip for another.

Where charges originate at the nursing station, the nursing unit gets its cards from the business office already slotted for "Nursing Station Number" and "Inpatient." This is done with a grooving machine which notches a group of cards for a single classification in one operation. Cards showing services rendered, forwarded from the special service department, are grooved in the business office as to department rendering the service and the date of service. Miscellaneous information, including accommodation, details of service rendered, and adjustment factors (such as Blue Cross) is punched after the business office receives the charge ticket. Wherever possible, cards are gang grooved for common information.

The charge ticket serves the dual purpose of entering charges on patients' accounts and providing basic information for statistical reports. This double value provides an answer to late charges and at the same time eliminates faulty or inadequate departmental statistics. It has the advantage, then, of assuring both prompt posting and basic accuracy.

Among the members of the Connecticut Hospital Association who have adopted this plan of controlling service charges to patients, emphasis is placed on different advantages. One administrator will be most interested in closing the gap between cost and payments of certain types of patients, while another will accentuate further administrative controls made possible. With such information it is relatively easy to determine if increasing personnel in the few departments which pay their way, such as physical therapy, will increase income.

Some of the larger hospitals, such as Grace-New Haven, St. Francis Hospital in Hartford, and St. Mary's Hospital in Waterbury, like to go even farther in their analyses to determine the areas of the hospital where the demand for service is greatest. Administrators of some of the smaller hospitals with fewer than 100 beds, such as Sharon Hospital, Rockville City Hospital, Litchfield County Hospital in Winsted, Mount Sinai in Hartford, and Windham Community Memorial Hospital in Willimantic, have found that the standard routine involved in the procedures surrounding the use of charge tickets has resulted in increased revenue.

These routines have eliminated failures to originate charges and losses in transit. This tangible source of additional income is readily explainable to the hospital's board of trustees. In most hospitals the broader avenues of administrative control made available by additional information prompt them to modify their procedures to get desired information; and even to change the desire for information when its availability is made known.

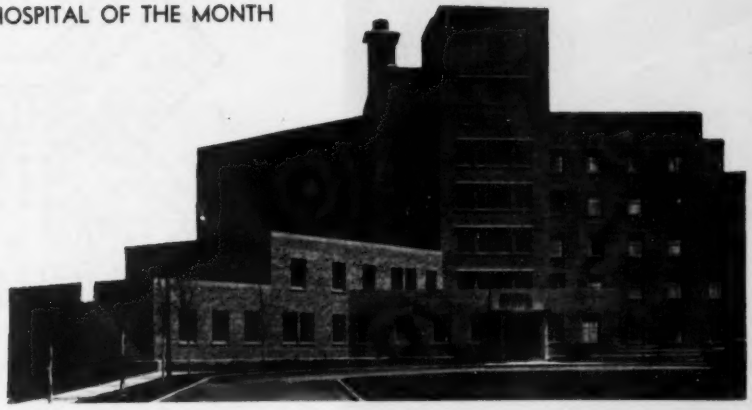
Most Connecticut hospitals have outpatient departments. Until the adoption of a standard charge ticket with a standard routine, many of these outpatient departments collected charges from outpatients in a haphazard manner, often without a record of bills rendered. A standard routine has eliminated the failure to charge for service to outpatients, which incidentally has increased income to some hospitals. This standard routine not only has eliminated the previous failure to charge for all service performed, but also provides the adequate and reliable statistics necessary for dividing outpatient service from inpatient service.

REIMBURSING AT COST

Notable among the results is the fact that all of the "third party" agencies, including the insurance carriers in the state, are reimbursing on inpatient services at cost to all hospitals following the uniform plan. Our experience in Connecticut has shown that a businesslike approach to the problem of hospital cost analysis and the consequent recovery of cost for services rendered from third party agencies overcome any argument that can be presented. And with more than 60 per cent of the hospital income depending on these agencies, it is obviously important that this be so.

It is remarkable how these agencies fall in line when reasonable requests for cost recovery are presented. In one case it was accomplished by correspondence alone, supplemented by a little auditing to substantiate the facts presented.

In another it was found that utilization figures could be obtained for all the special services provided, an important fact in obtaining increases in payments to reflect the factor of greater utilization of these services by this class of patient. It is little wonder that in only six months of experience with the new plan, the Connecticut Hospital Association is enthusiastic about the results.



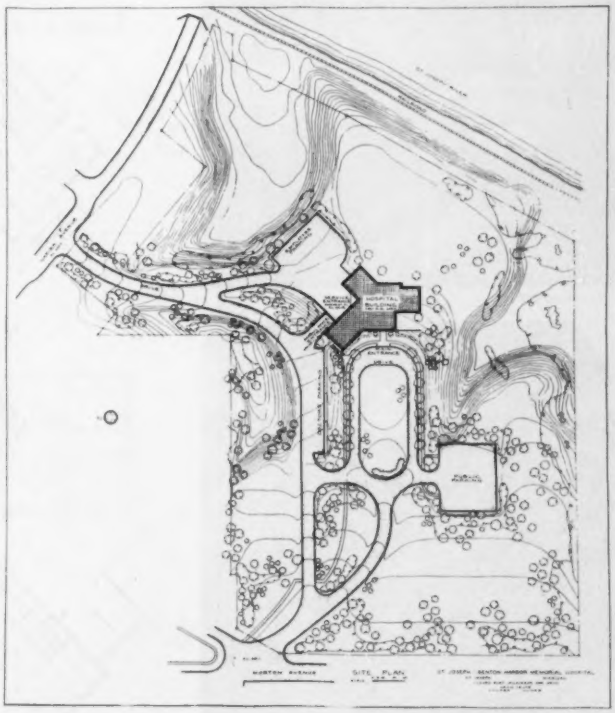
The site provides THREE ENTRANCES on THREE LEVELS

JOHN R. FUGARD
Architect, Fugard, Burt, Wilkinson & Orth, Chicago

CRESTING the plateau which overlooks the St. Joseph River to the east and Lake Michigan to the west, the St. Joseph-Benton Harbor Memorial Hospital, St. Joseph, Mich., commands also a view to the north of the two adjoining communities which, in cooperation with the federal government, made the project financially possible, and from which the hospital derives its name.

The architects have taken advantage of the unique configuration of the site which, to the west, falls away rapidly from the crest of the plateau to the St. Joseph River. Deep excavations, made years ago, as clay pits, gouge into this otherwise uniformly sloping terrain. An opportunity was thus afforded the designer to provide for the three principal entrances requisite to a well ordered hospital, each on a

(*Continued on Page* 86)

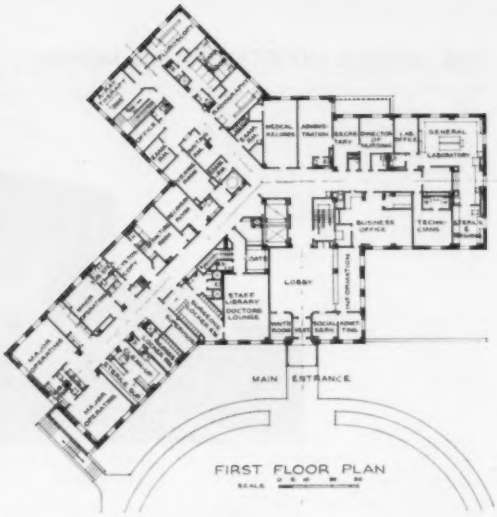


Total project cost, including equipment	$1,639,137.41
Cost per bed	$15,038.00
Cost per square foot	$18.97
Cost per cubic foot	$1.58
Total square foot area	86,387
Square feet per bed	793

LABORATORY

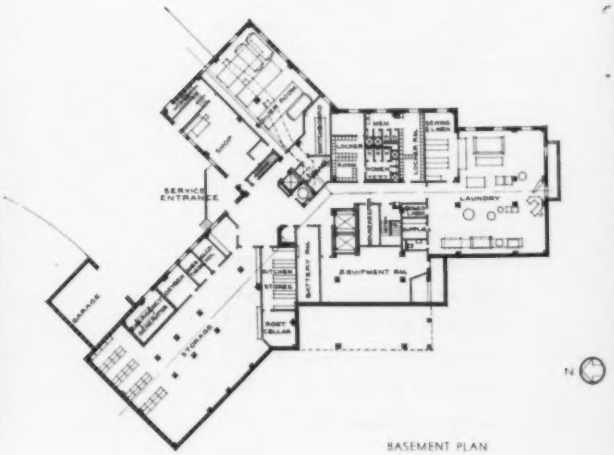
PHARMACY

KITCHEN

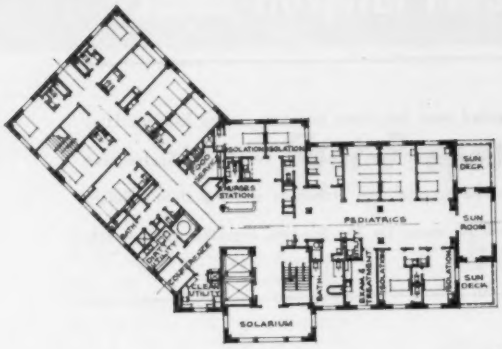


FIRST FLOOR PLAN

GROUND FLOOR PLAN



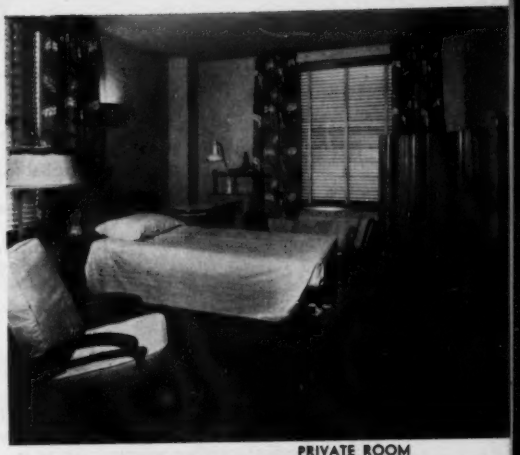
BASEMENT PLAN



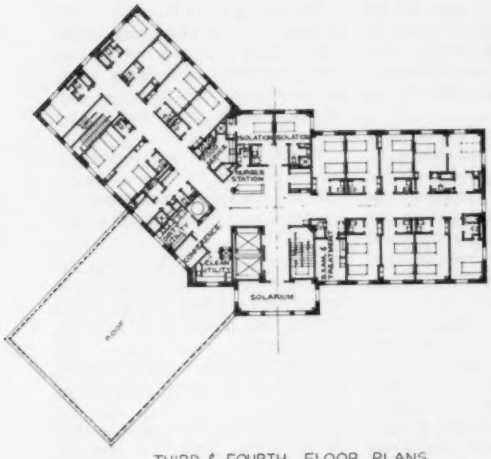
FIFTH FLOOR PLAN

SCALE

N



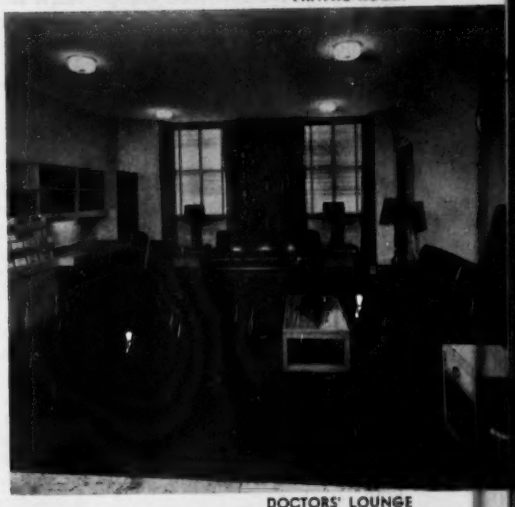
PRIVATE ROOM



THIRD & FOURTH FLOOR PLANS

SCALE

N

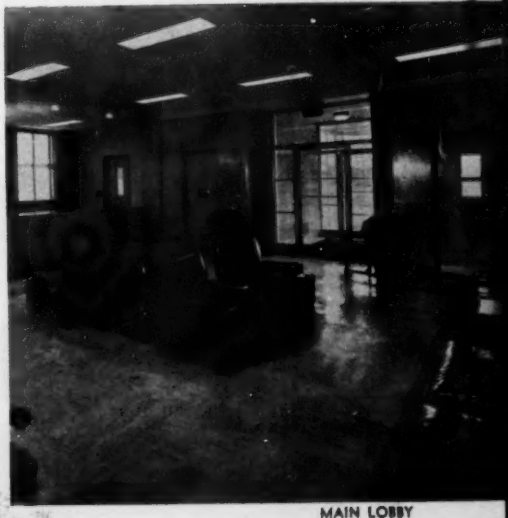


DOCTORS' LOUNGE

SECOND FLOOR PLAN

SCALE

N



MAIN LOBBY

The Modern H[illegible] Month

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

different level, each interconnected with roadways having easy gradients, and most important, each entrance providing access to areas of separate and distinct hospital operation without the overlapping confusion associated with so many single level designs.

In this case, the service entrance to the storage, laundry, dual emergency power equipment and boiler plant facilities was placed at the lowest, or basement, elevation. The ambulance entrance at the ground floor is a full story higher than the basement floor. It serves the emergency department and also provides access for stretcher cases, and for doctors, nurses and technicians, the doctors' parking area being at this same elevation. In general, the ground floor is a distribution area. Requisitions for supplies from the pharmacy and central supply departments are filled and delivered via dumb-waiter to the surgeries on the first floor and to the nurses' stations on all other floors. Other dumb-waiters deliver the food trays from the kitchen to the food service rooms on all typical floors.

The main entrance to the hospital first floor is a full story higher than the ground floor and is at an elevation approximating that of the crest of the plateau, and readily accessible to the public, outpatients and visitors. On this floor are located the administrative offices, x-ray suite, surgeries and diagnostic facilities.

The second to the fifth floors inclusive are devoted to general medical purposes with quarters provided for obstetrical, pediatric and isolation cases. A strategically located nurses' station on each floor is designed to obtain the maximum of visibility and nursing control.

In addition to the problem of taking advantage of unusual site conditions, the architects were faced with the problem of making provision for future hospital extensions, with the resultant analyses on orientation, and on the possible future loads on structural, mechanical and electrical construction.

Structurally, the building is of reinforced concrete with face brick and stone trim exterior, masonry interior partitions, birch and hollow metal doors set in metal frames, floor surfaces of asphalt tile, rubber tile and terrazzo, wall surfaces of plaster, ceramic tile and structural facing tile. The ceilings in corridors and public spaces are of acoustic tile. Fortunately, the use of copper, bronze, stainless metal and aluminum was not restricted under the national preparedness program in this now nearly completed structure.

The heating plant is equipped with package type of oil-burning boilers with automatic controls for all associated equipment. Convectors in the rooms are served by a down feed, zone controlled steam system with vacuum returns.

Ventilation, under temperature control, is provided for enclosed spaces, and, in connection with a cooling system, for surgery, obstetrical and nursery quarters.

The water supply from the city main is protected from a drop in pressure by means of house pumps. Water softeners are provided for the hot water system.

Oxygen is piped through a manifold system to each patient room and all surgeries.

The light and power systems from the transformer vault have been designed for hospital needs, and the fixtures have been selected for efficiency and appearance. Other electrical facilities include x-ray equipment for radiography, fluoroscopy and deep therapy; a nurses' call and telephone outlet at each bed; doctors' call, and in-and-out indicator systems.

Left: Corridor of the pediatrics unit located on the fifth floor. Right: Central supply section.

First Prepare the Budget Then Establish the Rates

JOHN H. GORBY
Administrator
La Mesa Community Hospital
La Mesa, Calif.

THIS outline has been written with the budget of the small hospital in mind. Our larger brothers usually have an accounting department headed by an experienced accountant, frequently a C.P.A. The use of budgets and the scientific preparation of rates comes as naturally to these experienced persons as planning the day's meals does to the housewife.

We can start with the premise that the budget is a valuable tool for economical and efficient operation. It is my intention to present the mechanics of budget preparation in logical steps. Each phase can be completed in a minimum of time and yet the result is a complete budget, workable and understandable.

NO CONTROL OVER COSTS

Some hospitals first establish rates, estimate total income, and then endeavor to spread the expense to approximate estimated income. I do not agree with this method. It is haphazard, gives no control over costs, and there is always the tendency to overestimate income. There is no real connection between income and expense and there is a distinct possibility of lack of revenue to meet already committed costs in the latter part of the year.

We are accustomed to express the work done in our institutions in terms of service. Therefore, the approach to the budget should be in terms of the service that we propose to render in the new operating year ahead.

Is there a planned addition that will be in operation next year? Will another wing be open, or additional personnel employed to operate a portion of the plant closed down for lack of nurses? Are you in a so-called "critical defense" area that will bring with it an ever-increasing population whose hospital needs you must be in a position to serve?

These are some of the questions you must answer as you plan for the year ahead. Using that always handy yardstick, the "patient day," it is quite possible to make a trend analysis of your occupancy for the past four or five years and forecast with remarkable accuracy your occupancy for the months ahead. But for budget purposes it will probably be sufficient to estimate in round figures the service you propose to render. If you maintain an outpatient department, it is essential that this be kept as a separate calculation as there is a distinct variation in cost.

The first step in the preparation of a budget should be the selection of the proper accounting period. Many hospitals are on a fiscal year or a 12 month period ending other than December 31. Other hospitals are on a calendar year basis, and there is still a minority that recognizes no year at all, and apparently never closes its books. Whatever period of time is selected should be far enough in advance so that the completed budget represents the combined thinking of all concerned, and is approved by the governing board prior to the time it is to be placed in operation. For a calendar year starting Jan. 1, 1952, September 1951 is not too early to start setting up the work sheets.

The completed budget is only as good as the amount of preparation, thought and care that has entered into its construction. There is far more chance of having a budget that each one in the hospital understands and uses if some time has been spent in its preparation. I have seen budgets prepared between Christmas and the New Year and presented to the startled department heads of a hospital with the wishful thought that they will operate smoothly under it. Nothing could be farther from the truth.

There should be complete and frank discussion with all supervisory personnel in the hospital. What departments are understaffed and should have additional help? Is there any relocation of duties that might result in more efficient operation with a "lower" salary cost for that particular department? In the matter of operating supplies the question should be asked: Are supplies being carefully and economically used? It is absolutely necessary that a clear picture of all that the hospital proposes to do in the year ahead be laid out before it is possible to estimate the cost of the proposed operation.

I would like to recommend the use of 13 four-week accounting periods. By no other method is it possible to ensure effective periodic comparison. The first period can start at the close of your existing accounting period. Then all that is necessary to do is to obtain a large calendar wherein the 12 months are portrayed on one sheet and mark it off in 13 four-week periods.

The periods are numbered and known as first period, second period, and so on.

CAN BE EVENLY DISTRIBUTED

This plan is particularly well adapted for budget control purposes. The final annual figure can be divided into 13 equal parts and evenly distributed over the year. If a 12 month period is used, there will be times during the year when five weeks will occur and distort the budget result. If you prefer, for simplicity, the traditional 12 month periods, then may I suggest that you weigh your monthly estimates for the four 30 and seven 31 day months. Just as a simplified example to make the point clear, assume a budget figure of $36,500 for dietary costs, then the 31 day months would be allowed $3100 and the 30 day months $3000. A small difference, perhaps, but a job worth doing is worth doing well.

After the accounting period has been selected, various historical data

Condensed from a paper presented at the Association of Western Hospitals meeting, May 1951.

for the nearest preceding 12 months will be required. At this point, we must make the assumption that your institution uses the recommended chart of accounts of the American Hospital Association, and that any item of capital outlay has been properly charged to the appropriate asset account. The data selected for your purpose should be as follows: Gross income for the 12 month period referred to, broken down into 5 groups: (1) pharmacy, (2) laboratory, (3) x-ray, (4) operating room and delivery room, (5) general services. The reason for this will be apparent in our discussion of rate fixing. Next, you will need the total expenditures for the same 12 month period divided into nine major classifications: (1) administration, (2) dietary, (3) household and property, (4) nursing services, (5) operating room and delivery room, (6) x-ray, (7) laboratory, (8) other professional services, (9) long-term interest.

O.P.D., NURSING SCHOOL EXCLUDED

Included under *administration* are taxes other than property taxes, provision for bad debts and short-term interest. *Dietary* would, of course, include the cost of food used, supplies and pay roll. *Household and property* would include the items of laundry, housekeeping, heat, light, power and water, maintenance and repair, depreciation and property taxes, property insurance, rent and ambulance service. *Nursing services* cover other than operating room or delivery room personnel, the nursery and nursing supplies and education. *Other professional services* include medical records and library, pharmacy, physical therapy, and social services. You will note that I have excluded outpatient department and nursing school from the list of expense items.

If you have either of these services they, of course, will be added. The expense for the period should then be divided two ways, salaries and other expenses, and the resulting figures reduced to cost per patient day.

If you have actual department heads, they should now be asked to submit to you their requirements for the accounting period you have selected. The department heads should estimate the number of personnel and salaries, supplies and operating expenses for the department, excluding overhead and any items of capital outlay.

If you do not have department heads, the job is up to you as administrator. Using the already prepared schedule of costs per patient day for the immediately preceding 12 month period, it is only necessary to multiply these costs by the estimated patient day load. The one item that will require extensive consideration is that of salaries. Remember, we are working possibly 15 months in advance. We must take into account not only the annual increases for tenure, but any contemplated changes in union agreement or working conditions. For example, adding a pension plan could make a significant increase in the cost of salaries. Vacations, sick leave, and expected turnover should also be weighed. I realize that it is easier to take last year's cost, add a few thousand dollars to it for good luck, and call that a salary budget. While some uncertainty is inevitable, it will be found after a little study that it is possible to estimate the cost of pay roll fairly accurately. For example, such a major policy matter as a change in the vacation policy is thoroughly discussed at the regular meetings of the governing board for several months in advance.

Perhaps the best way to set up your work sheet is to use one of the large 13 column distribution sheets. On the left-hand side under item description, insert the same expense accounts as were discussed earlier. The next column will be your estimated cost per patient day for salaries, with a separate column for operating supplies and other general expense items. These totals will then be multiplied by your estimated patient day load. Two or three columns farther over, set in the amounts that you have estimated for capital outlay. No item of a capital nature should be included in the expense account.

While you have under consideration capital outlay, also take into account the desirability of setting up a cash reserve. This is in addition to a reserve for noncollectible accounts. The mechanism of the budget makes it particularly easy to accumulate a sizable cash reserve. This should be deposited in a savings account or invested in securities at the discretion of the trustees.

The grand total of these accumulated items becomes our estimated expense budget for the year. If you are going to use the suggested four-week account period, divide the total by 13 to arrive at the amount available for each period. If you prefer the traditional 12 month period, divide by 365 and multiply by 28, 30 or 31 to arrive at a correct figure for the month in question. Expenses for each month should be carefully charged against the appropriate accounts and a gain or loss over the budget figure should be carefully noted.

If a department has been able to effect a savings over its estimated expense requirements, this does not necessarily mean that the department should be allowed that saving to spend as it so desires, probably for some item that was not included in the budget. It is much better to give those responsible praise for a job well done and stimulate them to greater efforts. One word of caution: "The preparation of the budget should never develop into a guessing contest between the administrator and the various departments of his hospital."

NOW ACQUIRE THE MONEY

The budget is now complete and out of the way. The second, and perhaps most important, part in the procedure is to establish the rates that will bring in the sum of money we have estimated will be required to operate our hospital for the period ahead. It was suggested that in our collection of data we divide gross income into laboratory, x-ray, pharmacy, operating room and delivery room, and general services. If the laboratory and x-ray are leased out or on some sort of fixed income basis, these two service departments can be set aside. If your income from these two sources is $10,000 for the year, this fixed amount can be used to decrease the income that will be necessary from the other departments.

The decision should now be made as to the amount of revenue that should be realized from general services, that is, room and board of the hospital. Hospitals traditionally sell their ward beds below cost. For purposes of illustration let us pretend we are at least going after cost and plan on raising 75 per cent of our estimated income from our general services. Presumably, in the determination of the estimated patient days for the year, some sort of formula for occupancy was used. In order to illustrate the method, let us settle on the theoretical norm, 80 per cent. From this point on, the formula is a simple algebraic computation. Apply the estimated occupancy against the total capacity of the hospital divided into classifications of private, semiprivate and ward beds.

For example, we will reduce our 50 bed hospital to an accounting basis of 40 beds. Next, let us determine what proportion of our ward bed rate, which is the basic rate, should be charged for semiprivate and private room accommodations. Experience indicates that in most hospitals the ratio is two times the ward bed for the private room and 1¼ times the ward bed for the semiprivate. Solving for X, the unknown factor, gives us the amount that should be charged for the ward bed. The difference in our estimated income must then be realized from the pharmacy, operating room, and delivery room. Rates for the operating room and delivery room are now established on the basis of the number of proposed procedures for the year. If you will approach the establishment of your ward bed rate at a realistic figure approaching cost, you will be pleasantly surprised at how easy it will be to reduce your charge for operating room and delivery room.

In the setting of rates to be charged for our pharmacy we are, in effect, dealing with what we term an accounting markup. Assuming that we propose to raise $36,000 of our income from the pharmacy, this obviously will be represented by profit plus cost. If it is estimated that the cost of drugs and items to be used in the pharmacy be $30,000, then the average percentage markup will be 20 per cent. Your decision in this regard will have to be weighed by the amount of free drugs or floor stock that is used in your institution. Some hospitals give a surprising amount of their drugs away. Other hospitals charge for every pill and cotton ball that is used.

I think one final word of caution should be: Let us be sure we know where the money is coming from. How much cash do you have in the bank or do you expect to have in the bank on the first day of the year? For example, if you have allocated an item of $15,000 for capital outlay, unless you have $15,000 in the bank, you will not be able to spend this until November or December of the budget year for the simple reason that the money will not be available.

How Cold Is Their Coffee! Here's Why

A TRUSTEE with an engineer's training and a passionate interest in hot coffee recently tackled the timeworn problem of how to keep coffee hot at Wilmington General Hospital, Wilmington, Del. In a report to Administrator Ben W. Wright, Trustee Ernest N. May, chairman of the hospital's building committee, observed that one of the main problems was "to get somebody to stay with the job long enough to see what really could happen!"

"As usual," Trustee May continued, "the task fell to the Building Committee, who equipped himself with a thermometer, a pressure gauge, a pencil and paper, and a watch—and spent a week on coffee!" The following excerpts from Mr. May's report will show hospital administrators and dietitians how tough the coffee problem actually is:

Many temperature observations were made. The readings and conclusions are probably accurate to plus or minus 2°C. The rate of heat loss starting with 80° to 85°C. coffee poured into a *preheated* (67°C.) china *pot* seems to be:

5°C. in first 2 min.
Another 10°C. in next 5 min.
Another 10°C. in next 10 min.
or 25°C. in first 17 min.

A further loss of 7°C. occurs when that coffee is poured into a room-temperature cup. Another 6°C. is lost by pouring in cream. Hence 38°C. is lost before the patient has taken his first sip.

It is therefore easy to understand how coffee loses 38°C. and becomes 45°C. which is "cold" coffee in anybody's language. If the china pot is not really preheated, if the time lag exceeds 17 minutes from urn to patient, the final temperature is even lower than 45°C.

Opinions vary on what constitutes palatable "hot" coffee but it is believed best to strive for the hottest. Accordingly 70°C. at the bedside after cream has been added, is accepted as the goal. Is it possible, and if so, how?

TIME LAG IS MOST IMPORTANT

With respect to analyzing the time lag which is the most important factor, and the one hardest to insure against, one estimates that if 125 trays can be assembled, loaded and pushed from tray service in 25 minutes it would be an excellent performance. This is five trays assembled per minute; say one truck of 15 trays in three minutes.

It is doubtful whether the longest truck delivery distance can be kept under seven minutes with all the push and supervision in the world. This means that it might be barely possible, by adopting a first on—first off unloading principle, for only 10 minutes to elapse from urn to ward corridor plus another two or three more minutes from ward to patient, or 13 minutes most optimistically. This is equivalent to about a 20°C. loss. If the combined loss from cold cup and cream of 13°C. is added, the total loss to combat is 33°C. Then there is always the loss by waiting after the patient pours!

If 70°C. is indeed the goal, then in view of the foregoing 33°C. the coffee must leave the urn at 103°C. and have absolutely no time delay. If the 70°C. is shaded to 65°C. it still means 98°C., or practically boiling coffee. However, the perfection of operation demanded to avoid time delay in, say, 50 per cent of the trays is too much to hope for and, in our opinion, is not worth the inevitable wear and tear on nerves. Somewhere the law of diminishing returns comes in.

From the foregoing statements it is concluded that the sensible thing is to reconcile ourselves to what seems to be now physically impossible, to avoid the stress and worry of continual justified complaints and to change the system as follows:

1. Discard the china coffee *pots*.
2. Use that equipment instead for preheating coffee *cups*.
3. Provide vacuum jugs to be filled with 98°C. liquids to be poured into the preheated cup in the presence of the patient.

ST. VINCENT de PAUL and ST. LOUISE de MARILLAC made hospital history

By OTHO F. BALL, M.D.
President, The Modern Hospital Publishing Company, Inc.

A GALLEY slave slumped in his chains and, unnoted, a young priest removed the unconscious form and slipped into his place. Some say it is but a legend, but it easily could be true, for St. Vincent de Paul himself had suffered as a slave. He ever had compassion on all who suffered. The poor, the sick, the orphaned, the insane, the convicts, in all of them he saw God and to all he gave his love and care.

Five years after his ordination, St. Vincent was on a ship that was captured by Barbary pirates. Standing in the market place at Tunis, suffering with an arrow-wounded arm, he was sold to a seaman, but proving unfit for life at sea, he was resold to an alchemist who was seeking the philosopher's stone. The slave tended the dozen furnaces while his master taught him much of his medical lore. After a year the old man died and his son sold the priest to a renegade Christian, who compelled him to work on his high barren lands in an almost unbearable heat. Another year passed by and the godly personality and great faith of the slave won the cruel master back to Christianity and together they fled to France (1607).

CHAPLAIN TO QUEEN MARGUERITE

St. Vincent was born in 1581 in the province of Tuscany where in his boyhood he tended his father's swine. His father approved of his desire to enter the priesthood and sent him to the University of Paris where he was ordained. For a short while he maintained an academy for sons of the nobility and gentry. After his enslavement and escape, he spent a year and a half in Rome, then entrusted with a diplomatic mission to Henry IV, he returned to Paris in 1608 and was appointed chaplain to Queen Marguerite of Navarre.

He was an unassuming figure but with an eloquence that moved his hearers. Dark haired, olive-skinned, with a remarkably fine head and dark deep-set eyes that twinkled with humor, mischief and irony, none guessed that the meek, self-deprecating man, so gentle and kind, fought a passionate nature, now animated, now deeply melancholic. He was a godly man fired with desire to serve his God and the unhappy poor.

He was appointed in 1619 the tutor of the children of Philip Emmanuel of Gondi, General of the Galleys. There he remained for 12 years as chaplain of the household. During this period he began his great work which made him immortal. In France there were then only the very rich and the very poor and the great ladies took pleasure in relieving the misery of the poor. Under guidance of St. Vincent a Confraternity of Ladies of Charity was formed to look after the spiritual and material needs of the sick-poor, but fine as the work was, it was inadequate, for in the morning and in the evening when they were needed badly, the women had to be in their homes. Each day they provided two repasts, one in mid-morning and one in mid-afternoon. They ministered to the sick but shrank from any repugnant duties.

St. Vincent realized the need for women of humble position to aid in the care of the sick. On his travels about France he met numerous sturdy peasant girls who were eager to devote their time to such a cause. If they could be properly trained, these strong young women might solve the problem. It was here that Mme. de Gras (St. Louise de Marillac) joined with him in the great epic of hospital history. The story of their magnificent accomplishments from that time on must be told together.

Louise de Marillac, born in 1591, 10 years after St. Vincent's birth, was the daughter of Louis de Marillac, lord of the manor of Ferriéres, councillor to Paris, and the niece of Chancellor Michel de Marillac and Louis de Marillac, marechal of France. Charming and beautiful, born to high estate, educated beyond other women of her time, she might have enjoyed great political and social influence. She chose poverty, exhausting labor—a servant of the poor.

WISHED TO BECOME A NUN

At the age of 15 she wanted to join the Capuchin nuns but was refused because of her delicate health. She later married Anthony de Gras and bore a son. During her happy life with her husband, she gave much time to caring for the sick-poor. When her husband died when she was 34, she wanted to devote her life to good works. St. Vincent sent her on long visits to the branches of his Associations of Ladies of Charity where she taught village women to care for their sick, organized classes for children, and found women to carry on these classes; she also recruited workers in the field. These frequent pilgrimages continued

St. Vincent entrusts the foundlings to the care of St. Louise.

for many years and the long trips by farm cart or on horseback took their toll of her health, which was never robust.

The nucleus of the great order of the Daughters of Charity, was formed through the joint efforts of St. Vincent and St. Louise. Each disclaimed credit for the foundation, attributing the work to God alone. Formed at first to care for the sick in their homes, the work of these Daughters extended into every project of the tireless priest. The young women were carefully selected from the strong volunteers from the villages and surrounding country. St. Vincent inspired them with great love and respect for the poor, for poverty was no disgrace in those that deserved charity—the young, the aged, the invalid, the cripple, those unable to obtain employment.

St. Louise with her educational background, her past experience among the poor, and her inborn capacity to train molded the rough country girls into tireless, capable visitors to the poor. Cheerfully they went wherever they were sent after their training period in cooking, sewing and care of the sick and their introduction to the spiritual life. Their mission was to look after the spiritual and bodily needs of the poor, never hesitating when duty beckoned them into filth or into danger. Soon the "gray sisters" in their peasant dresses with white collars and white kerchiefs on their heads were sought all over France. Volunteers were many and although St. Louise trained them as rapidly as she could, she still could not satisfy the great demand for their services.

While living in the household of the General of the Galleys, St. Vincent became horrified at the condition of the galley slaves. These convicts, when not in the galleys, lay chained in the dungeons amid vermin and filth, starved, sick and forgotten. In the galleys they sat chained to their seats in their nakedness, the lashes of the guards at either end of the boat urging them to exhaustive efforts. The sick lay untended in their chains.

St. Vincent called the attention of General Gondi to these conditions, and through the influence of Richelieu and his niece, the Duchess of Aiguillon, and the aid of the Archbishop of Marseilles, a hospital was erected for the sick galley slaves. Transferred from the hell in which they had been living, the convicts felt they had entered paradise. Their feet were washed, the vermin were removed, and they lay in not too uncomfortable beds, fed and served like men. No service was too repugnant for the Sisters of Charity.

After the death of Madame de Gondi, St. Vincent made a permanent home at the ancient Priory of St. Lazare (1632). The home for the training of the Daughters was near by. The great work of St. Vincent and St. Louise in the next quarter century is almost unbelievable. Enfeebled by his suffering during his slavery, by his penitential life, by long hours of labor in his far-flung missions and exposure to inclement weather during his endless trips, St. Vincent took no notice of his health, yet was ever solicitous of the health of those working with him. St. Louise was often prostrated by her endless hours of work and exposure to disease and he begged her to take care of her health. Often it seemed as though she were dying, but always she rose early from her sickness to meet new demands.

FINANCING A PROBLEM

There was always the problem of financing their extensive projects, but meek and self-depreciative as he was, St. Vincent did not hesitate to approach the rich and titled and the government itself to obtain funds for the many hospitals and other work of the Daughters of Charity. He was an able organizer with an ability to enthuse others in the work of saving the souls and bringing health to the bodies of the suffering poor, encouraging the donors and workers to persevere in the face of almost insurmountable difficulties.

Yet he was a deliberate person; none could hurry him. He explained that what may seem like a possibility in the beginning may be found detrimental as things progress or subjected to exasperating inconveniences. The Ladies of Charity and St. Louise often had to curb their enthusiasm and await his careful decision. Once when a Lady of Charity became urgent, he replied: "When God wished to save Noah and his family from the deluge, He commanded him to build an ark which could have been completed within a short time, yet he had him begin a hundred years before, in order that he might build it little by little. In like manner God wishing to lead the children of Israel into the Promised Land, could have had them make the Journey in a few days; nevertheless, more than 40 years passed before He gave them the grace to enter."

He was reluctant to enter any new enterprise until he had weighed the nature, the means and the odds. And yet, once assured of God's willingness, of the feasibility and righteousness of the project, nothing could withstand his earnestness. He had a passion for work, driving himself unceasingly, working with intrepidity and tirelessness, and by his earnestness, meekness and humility inspiring others to a universal charity. The rich listened to his impassioned appeals and gave money and jewels.

St. Vincent deliberated when Madame Goussault asked for organization of Sisters of Charity at the Hotel Dieu, but she went to the Archbishop of Paris and won his approval and St. Vincent quickly set St. Louise and her Daughters to work. This immense old hospital admitted 20,000 patients annually. Managed by overworked nuns, priests and visiting doctors, conditions were terrible. Beds designed for two held six; the dying lay with the recovering; a woman with a newborn beside her lay with a smallpox victim. Food and bedding were wretched, of hygiene there was none.

It is a long story of how St. Louise and her tireless Daughters of Charity with the support of the Ladies of Charity met this and other terrible conditions. The helpless foundlings, about 400 annually, were sent to a house called la Couche where they died of starvation or neglect or were sold to beggars who mutilated their limbs to obtain sympathy and alms. St. Vincent who loved little children and is always shown with them in his arms, established a home for them. The deserted infants were first put with wet nurses and visited by the Ladies of Charity until the nursing period was over and then returned to the home where they lived until they were apprenticed or put into service. It has been reckoned that within a quarter century more than 40,000 foundlings were rescued from starvation.

The insane, long neglected, starved and abused, also aroused the compassion of the lowly priest and to them the Daughters were sent and they received nourishment and kindly care. Homes were established for the aged poor. When the plague came, the Daughters went fearlessly to work among the victims and some lost their lives, but other Daughters quickly stepped forth to take their places. When war raged, St. Louise's Daughters with an amazing patience nursed the injured soldiers and the suffering people and gave them spiritual strength.

St. Louise had long wanted to take her vows but St. Vincent had deliberated thoughtfully. An entirely new Order would be established, not of cloistered nuns but of Sisters of Charity who went into the world to nurse the sick. In 1642 she and four of her Daughters took vows for one year, the vows being renewed annually, and thus began the great Order which today has 40,000 Sisters, with 200 establishments in this country and many others in every country. The establishments consist of schools of every grade and college, schools of nursing, hospitals, homes for the aged, for infants, for incurables and for unmarried mothers, child care institutes and mental hospitals. Although there is a large staff of nurses, visiting nurses are not maintained in this country except in Boston, for visiting nurses in the United States are provided by secular organizations.

St. Louise was 68 years old when she died of gangrene of the arm, caused by an unhealed wound from a fall. A few months after her death, St. Vincent too was gone. A few years later he was canonized but it was not until 1934, two and three-quarters centuries after her death, that St. Louise was canonized.

The magnificent work of these two great souls cannot be told in so brief a biography. Their contribution to the history of development of hospitals is inestimable, and the seed they planted has grown into a great tree. The greatness of the organizers lay in their ability to enlist the help of many in providing the funds and in training young women into service of the sick-poor. St. Vincent and St. Louise, humble and self-effacing, in their vast variety of undertakings, provided care for suffering mankind in their own generation and in all the generations to come.

Bibliography

Emanuel, C. W.: The Charities of St. Vincent de Paul. Washington, D.C.: Catholic University of America, 1923.

Lovat, Alice: Life of the Venerable Louise de Marillac. New York: Longmans, Green, 1917.

Leonard, J.: St. Vincent de Paul. In Williamson, Claude: Great Catholics. New York: Macmillan Company, 1940.

MacDonald, Isabel: St. Louise de Marillac. Brit. J. Nursing **83**:68, 96, 1935.

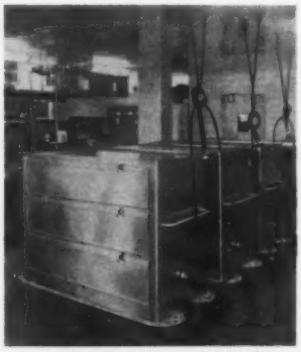
Woodgate, M. V.: St. Louise de Marillac, Foundress of the Sisters of Charity. St. Louis: Herder Book Co., 1946.

Ceiling Outlets Prevent Accidents

THE installation of special ceiling outlets for electrical power has done away with a serious problem in connection with the use of electrically heated food carts at the General Rose Hospital, Denver.

General Rose Hospital distributes food to all floors in the building via stainless metal, electrically heated carts, which must be "plugged in" for preheating, at a set interval, before meal serving time.

Instead of providing electrical power through wall outlets, as is usually the practice, and incurring the risk of falls through tripping over cables laid along the floor, the General Rose Hospital solved the problem by the installation of eight suspended ceiling power outlets at the kitchen entrance. As shown in the photograph, suspended from each outlet is a 6 foot length of cable, which provides a strong, handy connection for from four to eight electric carts at a time. When the two heavy rubber cables are loosely knotted, as shown, the extension cord that connects with the carts is pulled through, providing a strong support, which keeps all of the cords well up off the floor and out of the way during the entire preheating period.—BERT MERRILL, *Denver.*



Six-foot cable is suspended from the ceiling and connected to carts.

About People

Administrators


A. B. Mills

Alden B. Mills, who has served as administrator of the Huntington Memorial Hospital, Pasadena, Calif., for the last six years, has accepted the directorship of Mountainside Hospital, Montclair, N.J. While at Huntington, he took an active part in planning the new Jenks Convalescent Building and also the new research building, the Institute of Medical Research, which has not been completed. Under his administration, the affiliation of the hospital's school of nursing with the University of Southern California was effected; the program of practical nursing education in cooperation with Pasadena City College was developed; occupational therapy to patients through support of the Assistance League of Pasadena was made available; the hospital's first-aid department was expanded; a "rooming-in" program for maternity patients was inaugurated, and in-service training for new employes of the hospital was provided. Before going to Huntington Mr. Mills served as managing editor of The Modern Hospital for 12 years. Vice president of the Hospital Council of Southern California, he also is a member of the American College of Hospital Administrators, American Hospital Association, Association of Western Hospitals, Association of California Hospitals, in which he served on the council on professional relations, and the National League of Nursing Education. **Warren G. Rainier,** who has been serving as acting director of Mountainside, will be associated with Mr. Mills in the future administration of the hospital.

J. B. Franklin is retiring from his post as administrator of Tallahassee Memorial Hospital, Tallahassee, Fla., following 40 years of service in hospital administration in the South. He began his career as superintendent of the Texas Baptist Memorial Sanitarium, now the Baylor University Hospital, Dallas, Tex. Following a rest at Inverness, Miss., Mr. Franklin plans to do some hospital consultant work.

George Laycock has resigned his position as administrator of the Randolph Hospital, Inc., at Asheboro, N.C. His new position is as general hospital administrator on the staff of the High Commissioner of the United Nations Trust Territory of the Pacific Islands. In his new work, Mr. Laycock will make periodic visits to the seven hospitals scattered throughout the islands. He will confer with the administrators, help solve their administrative problems and make reports and recommendations to the U.N. **Noah W. Burrow,** present assistant administrator at Randolph, has been appointed by the board of directors to succeed Mr. Laycock.

Herbert A. Anderson has been appointed administrator of Lincoln General Hospital, Lincoln, Neb., effective August 1. He is the former administrative assistant at University Hospital, University of Michigan, Ann Arbor.


Dr. Gerald La Salle

Dr. Gerald La-Salle is the newly appointed assistant director of the Royal Victoria Hospital, Montreal, Que. Dr. La-Salle, who received his M.D. degree from Laval University, spent two years in the Royal Canadian Army Medical Corps. He recently completed his administrative residency at Royal Victoria which completes a two-year course in hospital administration from the University of Toronto.


R. O. West

Richard O. West succeeds **Dr. Joseph P. Leone** as administrator of Norwalk Hospital, Norwalk, Conn. For the last five years Mr. West has been director of Salem Hospital, Salem, Mass., and prior to that time he was director of the Portsmouth Hospital, Portsmouth, N.H., and assistant director of the New Haven Hospital, New Haven, Conn. He has completed his hospital administration course from the graduate school of the University of Chicago.


F. C. Sage

Frederick C. Sage has accepted the position of administrator of the Concord Community Hospital, Concord, Calif., succeeding **William B. Napton,** who has been recalled to active duty in the medical services corps of the air force. Mr. Napton will be stationed at McClellan Field, Sacramento, Calif. Mr. Sage has completed his administrative residency at Stanford Hospital under the Columbia University course in hospital administration.

Dr. F. Lloyd Mussells has been granted a leave of absence from his post as assistant director of Strong Memorial Hospital at the University of Rochester, Rochester, N.Y., to accept an appointment as deputy executive director, Committee on Medical Sciences, Research and Development Board, Department of Defense, Washington, D.C. Dr. Mussells received his M.D. degree in 1944 and he has completed the course in hospital administration at Columbia University School of Public Health.


F. H. Silversides

Franklin H. Silversides has been named superintendent of Children's Hospital, Winnipeg, Man. A graduate of the hospital administration course of the University of Toronto, he was formerly pharmacist, then assistant superintendent of the hospital.

Dr. Charles J. Barone, professor of obstetrics at the University of Pittsburgh Medical School, has been appointed director of the Elizabeth Steel Magee Hospital, Pittsburgh.

Robert Riggs is the newly appointed superintendent of the Jane Lamb Memorial Hospital, Clinton, Iowa, succeeding **Mrs. Margaret Kirkpatrick,** who resigned.

Dr. Christopher F. Terrence is the new director of the Rochester State Hospital, Rochester, N.Y., and **Dr. Richard**

(*Continued on Page* 162)

Conducted by Raymond P. Sloan

Where Do We Go From Here?

the emerging functions of the general hospital

SIGMUND L. FRIEDMAN, M.D.
Director, Mount Sinai Hospital, Cleveland

IF THE evolving functions of our acute general hospitals are adequately to be understood, we must first review some of the basic observations on the present state of medicine:

1. There has been an increasing degree of control over many of the infectious diseases.

2. The age of the population has increased significantly.

3. The so-called degenerative diseases have increased.

4. Stress is now being laid on the importance of a physically, mentally and socially healthy individual to himself, his family and his society. Put another way, this means only that we are accepting William A. White's view: "The oneness of body and mind, *the organism-as-a-whole concept*, and the interrelations between the organism and its environment, particularly the social environment, constitute an irreducible minimum of consideration that must be borne in mind if we are to arrive at any comprehensive idea of the patient and his illness."

5. There are evidences of changing concepts of the community's rôle in the maintenance of health, in the prevention, alleviation and cure of disease, in the rehabilitation of a diseased individual, and in his return to a state of health.

POSE NEW PROBLEMS

Obviously, these several observations mean new problems not only for medicine and physicians but also for hospitals and hospital administrators. The purpose of this article is to look at some of these problems.

Let us begin with the organism-as-a-whole concept (Point 4 above). The implications of its acceptance are many. For now, hospitals must do more than concern themselves purely with those patients who come seeking care for illness or injury. They must do more than practice the traditional medicine of an outpatient department, an inpatient or a follow-up service. They must interest themselves in the study of all etiological factors—and bring into their orbits students from all fields, provided only that these students have a contribution to make to the study of health and disease. The contribution may be a point of view or a technic; it may be ways of looking at facts or methods of accumulating and analyzing them. And, in addition, hospitals must gear themselves to care for the whole man, since medical care (prevention, treatment, rehabilitation) must make it possible for the individual to attain optimum health and his greatest efficiency in society.

These seem the logical responsibilities of hospitals; I would not deny that there has been, and is, much debate about them. They seem, however, so obvious that these points need not be belabored.

The implications of the acceptance of these responsibilities are many:

Hospitals must, first of all, do more preventive medicine. Not as, for the most part, they do it now—haphazardly and with little understanding (the notable exceptions are in pediatrics and obstetrics)—but as part of a program extending into all fields. Moreover it must be done on an individual basis rather than by utilizing the mass measures that have been practiced so successfully against some of the infectious diseases.

How many hospitals have established clinics in which physicians make periodic examinations of symptom-free adults? (Contrast this with the number of well-baby clinics accepted by physicians and parents as commonplace.) Yet, only by such inventories of health can the increasingly common degenerative diseases be controlled. This means individual attention to individual people—but that is the sort of medicine that hospitals practice. In this field, wholesale measures have, so far, proved useless.

Prevention of detectable disease, however, is not enough. Better health must be built. To this end, a new philosophy must be created; possibly, even, new methods of physical, emotional and social examination may have to be devised. Certainly, standards for the measurement of health will have to be established. This may be difficult to do, but the worthwhileness of the program is beyond question.

However, the establishment of well-adult clinics, as Stieglitz has termed them, by themselves is not sufficient. For these clinics must be held in readily available places, at readily available times, and the people must be taught to come to them (remember that this has been done in pediatrics and obstetrics). This means education, not only education in coming to the clinic and in following instructions but also education in health.

A start has been made in a few hospitals. But other hospitals show little, if any, interest in educating even those of their patients who return year after year with disease progressing because of sheer carelessness and lack of knowledge.

WHAT PREVENTION MEANS

Preventive medicine means more than well-baby and well-adult clinics. For the hospital, it means close cooperation with departments of health and the establishment of extensive working relationships that now exist in a few places only. It means concern with things with which, until recently, hospitals did not concern themselves—with which, indeed, many still do not. It means concern with food, clothing and shelter, concern with the economic and social aspirations of patients, concern with their discontents and their dissatisfactions, as well as with the whole multitude of stresses and strains to which people are subjected and of which they are the victims.

For the physician, a program of preventive medicine means concern not only with all these things, not only a new concern with his own reeducation and the proper education of his younger colleagues, but also concern with the health requirements of the citizen as a working being. The health re-

quirements of people vary to a large degree as their work varies. The health needs of the assembly line worker are different from those of the needle-trade craftsman, in the same way as their diseases may differ. Immediate necessities have forced on us a close study of diseases; ultimate necessities require just as intensive scrutiny of health problems.

Once begun on this road, hospitals will inevitably become involved in the problems of an industrial civilization.* True, they are already so concerned, but they must recognize that they are and must tackle the problems forthrightly.

For example, industrialization has meant the development of large plants with their assembly lines and attendant emotional problems that bring in their wake carelessness, accidents and absenteeism. These require intensive study, which none but the largest industries can afford. Cooperation between industry and hospitals becomes, then, imperative—no matter how difficult.

CAN BE MAJOR SERVICE

We must, however, deal not only with the big plants but with the many more small ones. Most of the former have fairly extensive health programs because they have found it to be good business. But the smaller plants, ordinarily, have no health services, and all too frequently are poorly equipped, with few safety measures and less interest in them. The provision of health supervision for such organizations can readily become a service of major proportions and one that will take the hospital not only outside of its traditional functional orbit but also outside its physical walls.

Again, hospitals must recognize that our industrial civilization, despite its technological success, has not learned how to achieve any but the smallest measure of social cooperation. The results of this failure directly and indirectly affect almost all the individual members of the community. The extent to which the members are affected is not generally realized—indeed, it has not been (and probably cannot be) assessed. We have no way of knowing how many persons have fallen ill because of the pressures of industry and of the civilization industry has helped create. Neither have we any way of knowing how many families have been broken because of these pressures exerted, through the workers, on their families.

There is a straight road from recognition of this fact to study of etiological factors in the industrial environment itself. And the road, though longer, is just as direct to sociological investigation of that environment as well as of the entire milieu in which man develops and lives. Both types of study are long overdue.

However, concern with the man who is well will not, at least in the forseeable future, completely replace solicitude for him who happens to have fallen ill.

Many of those who are ill today differ from those who were ill several decades ago. They are different because, as Brockington has pointed out: "Public health has changed society; it has changed its age constitution; it has abolished, speaking very broadly, infectious disease; and it has removed the more obvious causes of ill-health and death." For these reasons, among others, long-term illnesses have increased. The increase has been so marked that the Hospital Council of New York City has recommended, for its city, about 16,000 beds for the care of these illnesses (about two beds per thousand population).

Whether these beds are to be in the general hospitals or in special institutions has also been much—and hotly—debated. Just how the patient can be treated as a whole, and yet shifted from one special hospital to another as his illness or illnesses change, I, for one, cannot see. The difficulties inherent in treating a whole man become multiplied, and multiplied unnecessarily, under such a system.

To add these difficulties to the many we know will be unavoidable is to display an almost masochistic personality. We know, for example, that not only the patterns of living and the habits but even the mental and physical health and illnesses of the individual are those of his family and his society. We can, I think, safely say that there are few problem children or problem adults; there are, however, many problem families.

The individual can never be divorced from his family, no matter how long they may be separated. The psycho-physiological effects of the family on its members have not been adequately studied; indeed, they have been little more than mentioned except by a few. Such studies can best be carried out in and from hospitals; what this would mean if done on a large scale has been suggested in the publications of Richardson: alterations not only in medical approaches and technics but also truly extensive changes in medical and hospital practice. These would be difficult and costly. Yet, if care and treatment of the family as a unit is better than care and treatment of a single individual, can we avoid the undertaking no matter what the cost in money and effort?

But, to return to the long-term illnesses: despite their increase, despite the toll they take of lives and the health of families, despite their cost to the community in loss of productivity as well as in cost of treatment—these illnesses are usually of so little interest to the young physician, particularly to the intern and resident, that the so-called acute general hospitals have shifted the care of these patients to other institutions and have not bothered to look to see if these other institutions are able to cope with the most complex of diseases.

THEY ARE NOT "CROCKS"

The chronically ill are not "crocks." They are sick people, some of whom might never have become sick had it not been for our—for society's—negligence. Among them, too, are many who may still be returned, productively functioning, to society. They require—they must have—the best in scientific personnel, scientific performance, and scientific apparatus. And these are available only in the larger hospitals, most frequently in the larger acute general hospitals.

This method of caring for patients with long-term illness is not always feasible, nor is it necessary in all cases. But what is necessary is a program for their care, so that the proper facilities may be made available: hospital, custodial home, outpatient clinic, or complete care in the home.

Home care programs are not new; but only recently (at Montefiore Hospital in New York City) have complete and successful ones been established in several hospitals and one major municipal hospital system. An editorial in the *American Journal of Public Health* (February 1949) said this about the first program to be established, that at Montefiore:

"This program is designed for patients who, for one reason or another, do not require further hospitalization but do need continuing medical and

*This is aside from the hospital as an industrial organism itself.

nursing care. When preliminary study of a given patient indicates that the necessary domiciliary care can be provided with advantage to the individual concerned, the patient is transferred to his own home and the hospital supplies any or all of the following: medical service, at any hour of the day or night, with all necessary consulting specialist consultations; social service from the regular hospital staff; nursing care and instruction by the staff of the Visiting Nurse Service of New York, under a contract plan; housekeeping service, if indicated, to relieve the housewife for care of the patient; transportation to and from the hospital for special examinations or treatments; all necessary medication and appliances; occupational therapy and physical therapy in the home.

". . . . it is essential, however, to remember that its successful application depends on a high degree of hospital development in the fields of medical staff, social service, nursing, physical and occupational therapy. It would be most unfortunate if so fruitful a concept were to be discredited by wholesale displacement of patients by hospitals which lack the facilities to carry the program out successfully."

It appears unlikely that such home-care programs, operating out of hospitals, can be extended widely into the community in the immediate future. The hospital, however, here as elsewhere, must assume its share in educating the private practitioner in the use of the ancillary services which are already available but which he often does not know how to use fully. Should the private practitioners on a large scale become the leaders of groups caring for patients under a home-care program, the economics, as well as the sociology of medical practice, will undergo drastic revision.

To return people who have fallen ill to their economic and social places in society: this is one of the major goals of rehabilitation. The extent of the rôle the acute general hospital should play in the rehabilitation of the patient has been another contested point, but there can be little debate once the hospital accepts patients with long-term illness. Immediately, rehabilitation in all its forms becomes mandatory: physical rehabilitation, psychological and social readjustment, and vocational retraining so that the patient may become at least partially successful in productive work. True, few hospitals can, now or in the future, do all the work demanded by this program. And so, once again, cooperative working relationships must be developed—this time with agencies of municipal, state and federal governments as well as with several different types of voluntary agencies.

Mental illness is one of the chronic diseases the extent of which we can only guess at: some 8,000,000 persons in this country are believed to suffer from mental illness in some degree. The New York Hospital Council has recommended for that city 64,000 beds to care for this type of patient (8 beds per thousand population—as many beds for the care of this one illness as for all others put together).

It is unlikely that the care of most of these patients will pass from government to voluntary agencies. It is, on the other hand, likely that voluntary hospitals will undertake, to an increasing degree, research in psychiatric problems. This means not only investigation of the psychoses but study of all the emotional disturbances of man, his social maladjustments, his instabilities, and his difficult interpersonal relationships. And it means yet more: for it involves study of the interdependence of body and mind—psychosmatic medicine, if a label must be used.

The beginning of investigation into this area is the realization that the dichotomy between the physical and the mental, between the functional and the organic is false and is already being discarded. With this act of discard, the need for a combined biologic-psychologic approach becomes obvious. In the present stage of knowledge, this approach can be made only by qualified men from a half-dozen different fields working in teams: men from physics, chemistry, physiology, psychology, psychiatry, sociology and anthropology.

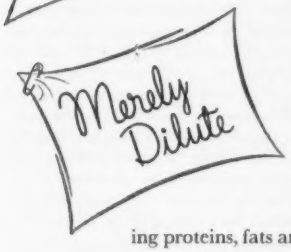
* * *

These are some of the problems confronting society and medicine in which the hospitals are involved. There are, of course, others—not only in the areas outlined but also in many not even touched upon. Among the last named are those created by the hospital itself as an industrial organism. These are far from negligible since the hospital, as a cooperative endeavor and as a comparatively small society, shares with the larger society its basic problems of communication and cooperation.

When Convenience is the Keynote

DEXTROGEN®

For Your Infant Patients



Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.

The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

THE NESTLÉ COMPANY, INC.

COLORADO SPRINGS, COLORADO

Conducted by Robert F. Brown, M.D.

GENERAL PRACTICE *is the standard*

by which the quality of medical care is measured

STANLEY R. TRUMAN, M.D.
Oakland, Calif.

THE general practitioner, as the family physician and medical adviser, is here to stay. The well trained general practitioner functioning in this rôle can deliver more medical care and better medical care more economically and with better consumer satisfaction than any other individual distributor of medical services can provide. I am not naïve enough to imply that all general practitioners are capable of delivering complete medical care, but in every community many of them can and do. It falls upon the leaders in the fields of health and medical care to encourage, inspire, develop and maintain highly qualified general practitioners.

NOT ANTI-SPECIALISTS

Family doctors are not anti-specialists, and we must plan for a *balanced* medical community, with a broad distribution of qualified general practitioners, with a ready supply of highly skilled and well trained specialists. Several years ago I made a survey of the patients coming into my office, and I found that the average patient, if he had sought the care of specialists for his complaints, would have required more than three doctors in contrast to one general practitioner.

Whether the doctors are gathered under one roof or under several roofs, the average American patient cannot afford the cost or the time to see three doctors when the same complaints can be handled in a single visit to a single doctor. Furthermore, it has yet to be proved that the sum of the parts, that is, a group of doctors each interested in a part of the body, equals the whole—one doctor seeing the patient as an entire entity in his total environment.

Not long ago I was called on the 'phone by an elderly woman. She said, "Dr. Truman, I want you to be my doctor." I knew her well, and I said, "Mrs. S, you have several good doctors. Where are you now?" She replied, "I am in —— Hospital, but *I* have no doctor. Dr. A takes care of my kidneys, Dr. B did my surgery, Dr. C is treating my allergies, but nobody takes care of *me*."

The King of England has his personal physician, the President of the United States has his personal physician, General MacArthur has his personal physician. I predict that every American is going to have *his* personal physician and that the general practitioner will come into his own as the physician who, by training, precept, and attitude of mind, and by interest, will assume the position of personal and family physician.

In the turmoil and readjustment of the last couple of decades the general practitioner has sometimes been pushed aside, but there has been an awakening on the part of the people and they are seeking and finding the family doctor, the personal physician. Yes, general practice is being recognized for what it really is—a broad, special field of medicine.

Since modern medical care requires hospitalization for all serious illnesses, injuries and maternity cases, it is essential that family physicians have an opportunity to practice in their community hospital. Family physicians, in turn, have a responsibility to the hospital. They must work with other members of the staff, the administration, and the governing board in order that the hospital may fulfill its functions.

The hospital has a social and moral obligation to take care of the sick needing hospitalization. Many hospitals, because of their excellent facilities and their great desire to contribute to expanding medical and health requirements, have embarked on programs of research, physician education, and resident training. I realize that hospital administrators are not solely responsible for all these activities, but we all know that (because of their key position) their ideas, their actions, and their philosophies carry great influence with trustees, medical staffs, and personnel.

HAVE EQUAL OPPORTUNITIES

Some of our friends have thought that the purpose of the American Academy of General Practice was to bring pressure to bear on hospitals to obtain hospital beds for its membership. This is not so. In a recent survey more than 97 per cent of the academy's members reported that they had adequate hospital facilities and were satisfied with their hospital relations. Furthermore, 99 per cent of small hospitals and 91 per cent of hospitals with more than 150 beds report equal opportunity for general practitioners and specialists.

There are places where general prac-

From a paper read before the Association of Western Hospitals, 1951, and modified for publication purposes by the author.

BETWEEN
POLLEN AND PATIENT...
AN EFFECTIVE BARRIER

When there's pollen in the air, and hay fever on a host of faces, your patients look to you to protect them. Fortunately, in BENADRYL you have a dependable barrier against the distressing symptoms of respiratory allergy.

Benadryl®

PIONEER
ANTIHISTAMINIC

For your convenience and ease of administration BENADRYL hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a wide variety of forms including Kapseals®, Capsules, Elixir and Steri-Vials®.

PARKE, DAVIS & COMPANY

MEDICAMENTA VERA

titioners do not have facilities for hospital care of their patients, and we feel that this is a matter of concern to hospital administrators, to us, to the public, and to the entire medical profession. Wherever and whenever doctors are denied hospital facilities, the standard of practice deteriorates and therefore the medical care of the community deteriorates.

No matter where you go you will find that the quality of medical care distributed to the community is measured by the quality of general practice in that community. Sir William Osler said of the general practitioner: "He is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him." This was so in Osler's time, and it is unchanged in our time. We all have a responsibility to maintain high standards of medical practice by every means at our disposal, and one of these means is a hospital staff relation for as many physicians as possible.

CONCERNED WITH ADEQUATE CARE

We are all concerned with adequate medical care, with sufficient amount of medical care, with adequate distribution of high quality personnel to distribute this medical care. One reason then that the American Academy of General Practice has drawn up a plan for the establishment of a department of general practice in hospitals is because in a number of key locations and key positions the highly specialized, highly academic environment could be given a more realistic hue by the incorporation of some leading general practitioners among the staff and personnel.

Almost 50 per cent of our population lives in communities of 4500 or less. In these localities, where the hospital is not departmentalized, there is no point in developing a department of general practice. It is only in highly departmentalized hospitals that a department of general practice should be considered.

What do we expect to obtain by a department of general practice in a hospital?

1. Closer cooperation and harmony among the doctors themselves.

2. Greater cooperation between the medical profession and the hospital administration.

3. Higher standards of the practice of medicine within the hospital and in the community.

4. Representation of all the doctors in the hospital with more active participation of a larger percentage of the staff in the responsibilities and activities of the hospital.

5. Better professional and hospital public relations.

Let's discuss a few of these items separately.

Representation. Ever since our forefathers fought and won a revolutionary war over the premise of the fairness of representation, American philosophy has been firmly rooted in this principle. When a department of general practice has been established in a hospital, this simply means that the members of that department, just as do other departments, will elect, select or have appointed their own representatives on the executive committee and other committees and among the officers.

Hospital Standards. Some have raised a question as to whether the establishment of a department of general practice might lower hospital standards. It has been found that the representatives of the department of general practice on the membership committee and on the credentials committee have been, in general, far more critical than their specialist brethren. I do not believe anyone can cite a case in which the quality of the staff or the standards of medicine in a hospital were lowered by the establishment of a department of general practice. I am sure that in everyone's experience the opposite has been the effect.

What cases will be assigned to the department of general practice? This question indicates a misconception. It is recommended that a department of general practice shall be an administrative department, and that there shall be no service of general practice established. We see no place for a general practice service unless the outpatient department could be so organized. In a few hospitals the outpatient services are being organized under the department of general practice, or else this is under serious consideration.

What shall be the function of the general practitioner in the highly departmentalized hospital? In a highly departmentalized hospital with special services available, the general practitioner should be assigned to special services in which he has some particular skill or interest or in which he wishes to acquire particular knowledge or skill. These assignments can be made by a simple procedure; the request of the physician for privileges in a specialty service should be passed upon by his own department and the chief of the specialty service involved and then forwarded to the credentials committee for action. The credentials committee should make its recommendations to the executive committee of the entire staff.

An excellent example of incorporation of general practitioners into a highly departmentalized teaching hospital and their assignment to various services may be found in Alameda County, California. Here the general practitioners are well integrated into the staff of the county hospital in the services for which they are fitted. In this hospital several general practitioners are assigned to the surgical service; others with a primary interest in internal medicine are assigned to the medical service. Several of the general practitioners are assigned to the contagious disease service and so on. It might even be desirable to rotate some of the general practitioners from service to service.

G.P.'S WANT TO STUDY

Like other physicians in the community, general practitioners in this hospital are stimulated by the opportunities for study and research. They actively engage in the teaching program; they are there for the resident staff to see (real, live general practitioners whom the residents had heard about in medical school but had never seen). The hospital is benefited, the community is benefited, the medical profession is benefited, and the young physicians in training are benefited.

We regret that there is, as yet, no department of general practice in Alameda County Hospital; therefore the general practitioners as such have neither voice nor vote in the affairs of the hospital. We are of the opinion that we would be more active, assume more responsibility, and that a great number would show interest if a department of general practice were established. The

Heyden PENICILLIN and STREPTOMYCIN

CONSIDER THE SOURCE!

Like an uninterrupted supply of motive power, Heyden Penicillin and Streptomycin serve the medical profession with quality and uniformity that are constant. Through advanced research and manufacturing methods, users of these superior antibiotics are protected against fluctuations in production, price and delivery. For these important reasons, outstanding consumers and packagers alike consider the source—and invariably the answer is Heyden Penicillin and Streptomycin!

BULK FORMS OF PENICILLIN, STREPTOMYCIN AND DIHYDROSTREPTOMYCIN

High-potency Penicillin, in hermetically sealed jars of 500 million units, 1 billion units, and drums. Special sizes on order.

Crystalline Procaine Penicillin G, Regular or Micropulverized, sterile.

Crystalline Penicillin G Potassium, sterile.

Crystalline Penicillin G Sodium, sterile.

Crystalline Penicillin G Potassium, tablet grade.

Streptomycin and Dihydrostreptomycin in bulk, for formulations in ointments, etc., available in 1 kilogram containers.

Packaged forms (Vials) of Heyden Penicillin, Streptomycin and Dihydrostreptomycin are also manufactured in all popular dosages, as well as Tablets (buffered and soluble) and Troches of Penicillin, sealed in foil.

FOR THE MANUFACTURER-DISTRIBUTOR: All popular forms of Heyden Antibiotics ready for private labels and packaging.

FOR THE MANUFACTURER: Bulk quantities for private formulation.

FOR THE DISTRIBUTOR: Labeled and packaged forms ready for sale.

Write today for fully detailed brochure covering all Heyden Penicillin and Streptomycin products.

CONSIDER THE SOURCE! . . . and you'll specify HEYDEN

HEYDEN CHEMICAL CORPORATION

393 SEVENTH AVENUE • NEW YORK 1, N. Y.

FINE HEYDEN CHEMICALS

end result would be a wider community service.

No one is becoming excited about this defect; there is no belligerency. We are holding discussions from time to time with the heads of the staff and the administrator. There is no rancor or friction for we all have the best interests of the patient, the hospital, and the medical profession as our goal. Unquestionably in the near future a department of general practice will be established.

What about general practitioners in university hospitals? I am thoroughly convinced that well qualified general practitioners could be attached to the specialty services of most university hospitals with marked benefit to patients, students and staff. A few general practitioners scattered throughout the teaching staff would do a great deal to bring theory and reality in closer proximity. If there are no such well trained competent general practitioners in the university community to fill this need, then it is the responsibility of hospital administrators and doctors to see that men are trained and made available for this important teaching purpose.

What about limitations of privileges? How shall we limit the privileges or distribute the privileges of general-practitioner members of the staff? Actually, this has been much less of a problem in practical application than it has been on theoretical contemplation. The American Academy of General Practice stands firmly on the principle that all doctors should limit their activities to those procedures that they have the skill, training and experience to perform.

SHOULD REVIEW PRIVILEGES

In each hospital there should be a credentials committee (or whatever name you may wish to call it). The responsibility of this committee should be to decide, upon the original application of each member of the staff, what privileges he shall be accorded. These privileges can be reviewed from time to time as training, ability or experience increase.

Fortunately for all of us, the level of self-criticism among the medical profession is extremely high. It is really a rare thing when a physician, either a specialist or a general practitioner, oversteps his ability. This rare individual, egoist, sadist or just plain greedy, causes a disproportionate burden of responsibility on the rest of us, but because

these persons exist we must all apply certain regulations and restrictions to ourselves. Formulated with reason and applied with fairness to all alike, these restrictions can be our guideposts to a fine type of medical care and actually a relief from some individual responsibilities.

An interesting communication recently came to my attention. A memorandum from the executive committee of the staff of a hospital in New York State to all members requests that the members of the various specialty departments "stay within the limits of their field. A department of general practice has been established, and if specialists wish to work in other fields than their own indicated field, will they please make application for membership in the department of general practice and function through that department."

Limiting one's activities to one's ability is a moral function and seems to be somewhat equally distributed among specialists and general practitioners. Within the year I have seen certified specialists overstep their abilities and training as often as I have seen general practitioners overstep their abilities. The anticipated tightening of the economy will add a temptation to some specialists to step outside the field of their training and experience. When it becomes necessary to discuss the curtailment of either general practitioner or specialist it gives great aid, comfort and moral support to the members of a committee to have mature, experienced, highly regarded general practitioners sitting with them around the conference table.

In summary, I should like to repeat that the general practitioner is an important part of the medical community. Because of his ability to distribute medical care more economically, because of his peculiar opportunity to treat the patient as a whole, and because the quality of medical care distributed to the public will be measured by the quality of general practice available, the general practitioner must be incorporated in all phases of medical care.

The hospital has assumed the obligation to furnish hospital facilities for the community. The hospital has the responsibility of contributing to the educational opportunities of the physicians of the community, and of training young physicians to fulfill the future needs for medical care. In fulfilling these responsibilities the membership of the hospital staff should be made up of all segments of the medical profession including general practitioners, and this is best accomplished by the establishment of a department of general practice in those hospitals that are highly departmentalized.

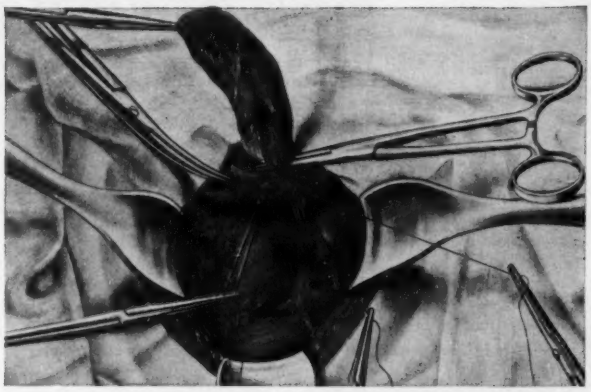
RAISES QUALITY OF CARE

The function of this department is administrative. It is not intended that a general practice service should be established, with the possible exception of an outpatient department. Whenever a department of general practice has been established it has been found that the quality of medical care has been raised, that a larger number of men are brought into active interest in the staff of the hospital, that closer harmony and cooperation have been established among members of the profession and between the hospital administration and the staff. In the majority of hospitals the general practitioners have been well coordinated, but in many of our larger urban and teaching hospitals the establishment of a department of general practice would seem indicated properly to integrate the staff.

The American Academy of General Practice has published a "Manual on General Practice Departments in Hospitals" (revised 1951). Its purpose is to provide a guide for the establishment and operation of a department of general practice that will result in improved integration of the family physician in his community hospital. Copies of this manual may be obtained from the academy's office, 406 West Thirty-Fourth Street, Kansas City, Mo.

As our communities continue to grow rapidly, many hospitals will become departmentalized. It is our hope that the larger hospitals that do not have a department of general practice incorporated in the staff will see fit to stimulate its development in the near future.

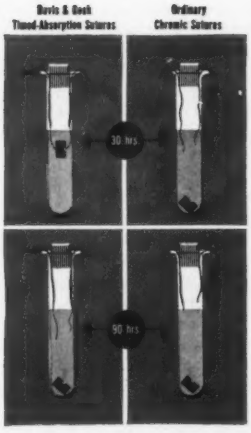
During the critical first 4 days depend on



"TIMED-ABSORPTION" CATGUT

Because "timed-absorption" catgut (surgical gut) has a *measurable* and *predictable* rate of digestion, demonstrated by extensive tests, it remains intact until the wound has gathered support of its own. Because "timed-absorption" catgut does not digest prematurely, it assures strength when needed most—during the critical first 4 days following major surgery.

Processed by an exclusive Davis&Geck method embodying accurately graded degrees of tanning, "timed-absorption" catgut has an absorption curve that parallels the changing tissue conditions of healing. Resistance to digestion is maximal during *early* repair. Later, when artificial strength is no longer required, dissolution is rapid and complete and no remnants of gut remain.



Comparison of D & G "timed-absorption" medium chromic catgut, size 0, with ordinary medium chromic size 0 catgut. Both types of catgut are suspended in a trypsin solution and weighted. Note that at the end of 30 hours D & G "timed-absorption" catgut remains intact; the weight is still held suspended up to 90 hours. Contrast with an ordinary chromic catgut suture which has begun to digest and breaks under the slight tension created by the weight at 30 hours. In human tissue all chromic sutures are digested *more slowly*, but the ratio between the two types remains the same.

D & G catgut sutures have a special matte finish. They tie readily and do not slip at the knot. Pliability is exceptional and tensile strength, diameter for diameter, is guaranteed unexcelled by any other brand. No wonder so many surgeons agree on D & G.

There is a D & G suture for every surgical purpose. Available through responsible dealers everywhere.

DAVIS & GECK, INC.

57 WILLOUGHBY ST., BROOKLYN 1, N. Y.

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

VITAMIN-ENZYME RELATIONSHIPS*

THE addition of vitamins to the armamentarium of drugs used in modern clinical practice should stimulate the interest of the physician, not only in the indications and contra-indications for their use, but also in the reasons *why* the vitamins should play such an important rôle in the economy of the human organism. The nutritionist is familiar with the deficiency diseases which are connected with the various members of that class of compounds which are called vitamins. He is also aware that it takes a surprisingly small amount of a given vitamin to alleviate the symptoms and signs of these deficiencies. The question arises as to why it is that the lack of such a small amount of material in the diet can give rise to so large an effect. It is the author's hope that the material herein presented will provide the reader with some insight into the mechanisms underlying the phenomena of vitamin deficiency.

A vitamin may be defined as an organic molecule which is essential in minute amounts for the normal growth, development and function of an organism and which cannot be synthesized in sufficient quantity by the organism itself. It was the smallness of the effective amount (microgram quantities) of the vitamins which impressed the early investigators, and it was on this point that correlations were first made which ultimately led to a reasonable exposition of their mode of action.

*The author makes no claim to originality for any of the statements contained herein, and asks his readers' indulgence for the lack of specific documentation. Most of the information is by now general knowledge for those familiar with the field. As a general bibliography the reader is referred to standard texts on biochemistry: The Enzymes, Sumner and Myrback, Academic Press, Inc., New York, 1951; recent volumes of the Annual Review of Biochemistry, Annual Reviews, Inc., Stanford, Calif., and Advances in Enzymology, Interscience Publishers, Inc., New York.

Vitamins Are Important in Enzyme Action:

In order to discuss the manner in which vitamins act within the body to produce their pronounced effects upon the health and well-being of the animal, it is necessary to inquire into those processes by which the cells maintain themselves and carry out those functions appropriate to the tissue in which they occur. A detailed consideration of the workings of the cell shows that it is essentially a chemical factory or machine which transforms the materials which are presented to it by the blood into cellular constituents and function. In order to do this the cell carries out many chemical reactions. The impressive thing about these reactions is that they are, in the main, reactions which ordinarily do not proceed spontaneously at any appreciable speed under the conditions of temperature, pressure and so forth which are found in the interior of the cell.

The cell, in order to make these reactions proceed at high enough rates to be useful, has evolved a group of substances which are known as enzymes. An enzyme may be defined as a biocatalyst. Catalysts are substances which, because of their unique molecular configuration, cause an increase in the rate of the reaction catalyzed without themselves being used up in the process. As a consequence of this last property a very small amount of catalyst can cause the transformation of a very large amount of material because the catalyst can be used over and over almost indefinitely. Enzymes have, in addition to their catalytic properties, the further property of being more or less specific for a given reactant or group of reactants. These reactants are generally referred to as *substrates*. Enzymes are named for the substrates whose reaction they catalyze, *i.e.* succinic oxidase catalyzes the oxidation of succinic acid. This property of specificity is most important because it is one of the main ways in which the cell regulates and guides its metabolic processes.

In the light of this discussion it is easy to see that if the cell is in some way prevented from synthesizing these vital components, the enzymes, then one might expect drastic changes to occur in the appearance and behavior of the cell. Further, enzymes, being necessary in only very small amounts, presumably require only small amounts of material for their synthesis. If the cell is unable to synthesize some vital part of the enzyme molecule, that part would be required in the animal diet in only very small amounts. The correlation between the smallness of the amount of enzyme required to catalyze the transformation of large amounts of materials and the smallness of the amount of vitamin necessary to maintain an animal in good health is at once apparent. It is not suprising then that a connection between the two substances, vitamins and enzymes, should have been found.

Character of Enzymes:

As our knowledge of the chemistry of the enzyme molecule progressed it was found that many enzymes were made up of two parts: the so-called apoenzyme and its prosthetic group. The apoenzyme part of the molecule is protein in nature, while the prosthetic group is usually an organic molecule more or less tightly bound to the protein part of the complex. If the binding between the two parts is loose and they come apart readily the prosthetic group is often called a coenzyme. Recent opinion holds that this is merely a matter of historical terminology and that functionally a prosthetic group and a coenzyme are identical.

A highly simplified picture of one of the best characterized enzymes, Cy-

For an unusually complete booklet with photographs and detailed drawings of the Westex, see your local representative or write to Westinghouse, 2519 Wilkens Avenue, Baltimore 3, Md.

The *Westex*

Today's finest value—backed by service

The new and sensational Westex, designed for your office, clinic, or hospital, is today's finest value in X-ray equipment. Combining features most desired by physicians and technicians, the Westex may be used in small rooms without crowding. Yet it has fullest flexibility, maneuverability, and efficiency.

What is more, the Westex is backed by the thorough and effective Westinghouse X-ray service network. Service and accessories are only as far as your telephone, and materials and service are available on a 24-hour basis. Whether men or materials are needed, they will reach you in the shortest possible time.

For full information about Westinghouse service, accessories, and equipment, call your nearest representative, or write to the address above. Remember, Westex and Westinghouse—names that mean value and dependability.

PHOTOTIMER · PORTABLE UNITS · TUBESTANDS · KACTRON · QUADROCONDEX · MONOFLEX · PTX · DUOFLEX · DUOCONDEX · SERVICE · ACCESSORIES

YOU CAN BE **SURE**...IF IT'S

Westinghouse

MEDICAL X-RAY

J-08353

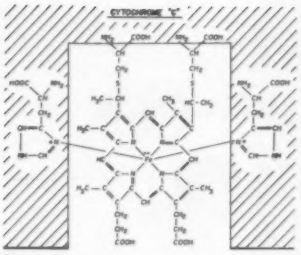


Figure 1.

tochrome C, is shown in Figure 1. Since we know very little about the structure of proteins, this part of the molecule is indicated by means of cross-hatching. The prosthetic group—in this case an iron containing porphyrin—lies in a fissure or hole in the protein part and is attached through sulfur and hydrogen bonds to the amino acid backbone of the protein. The prosthetic group is the reacting part of the enzyme. The protein part, because of its peculiar configuration, will allow only a certain kind of molecule to approach the prosthetic group, thus conferring on the catalyst the specificity which has been referred to.

It can now be said with a good deal of assurance that most, if not all, vitamins function as the prosthetic groups of enzymes. An explanation of the essentiality of vitamins is at once apparent. The vitamin is the part of the enzyme which the cell cannot synthesize and hence it must be supplied preformed in the diet. With this background we are now ready to consider the specific vitamins with respect to the enzymes of which they form a part and the reactions which they catalyze.

Biological Role of Specific Vitamins:

Nicotinic acid, the deficiency of which is the chief cause for the clinical

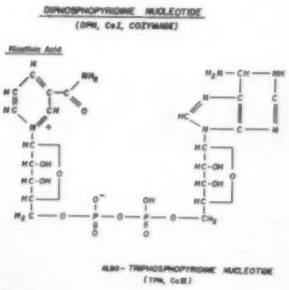


Figure 2.

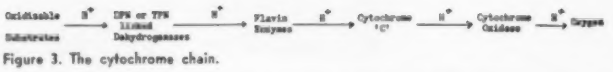


Figure 3. The cytochrome chain.

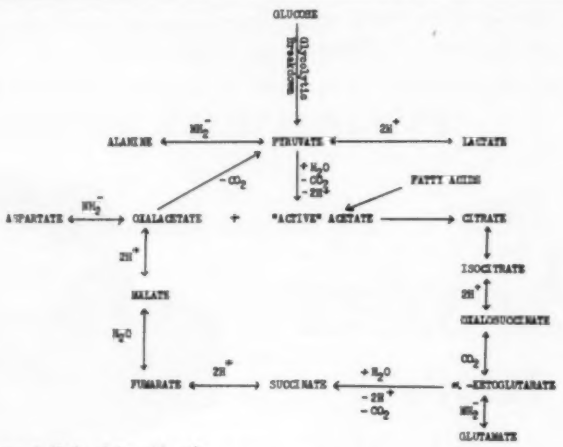


Figure 4. Krebs citric acid cycle.

condition called pellagra, is a part of the structure of diphosphopyridine-nucleotide (DPN) or, as it is more commonly known, Coenzyme I or Cozymase. Figure 2 shows the structure of DPN with the vitamin part of the molecule indicated by somewhat heavier type. DPN, or another closely related coenzyme triphosphopyridine-nucleotide, is the prosthetic group of a large series of enzymes known as dehydrogenases which catalyze the first step in the oxidative breakdown of carbohydrate molecules, namely the removal of hydrogen from the carbon skeleton. This hydrogen is transferred in a stepwise fashion down the so-called cytochrome chain until it eventually combines with oxygen to form water (Fig. 3). The bulk of the oxidation of carbohydrate, fat and protein is believed to proceed through a series of reactions known as the Krebs citric acid cycle (Fig. 4), and all of the hydrogen which is removed during these reactions is funneled out through the cytochrome chain. It is not surprising, then, that deprivation of nicotinic acid should cause a severe deficiency disease characterized by malfunction of cells.

Riboflavin is another of the B-complex which functions as a part of the cytochrome chain. Figure 5 shows the structure of two prosthetic groups, flavinmononucleotide and flavinadenine-dinucleotide, for the flavoprotein enzymes of the cytochrome chain (Fig. 3). Again the deficiency signs are attributable to a partial failure of this process of hydrogen transfer. There are, however, other unrelated enzymes, such as d-amino acid oxidase, xanthine oxidase and so forth, which contain flavin so the deficiency picture is not the same as that seen in pellagra. In these first examples we have been concerned with the disposition of the hydrogen resulting from the oxidation of the carbohydrate. We shall now

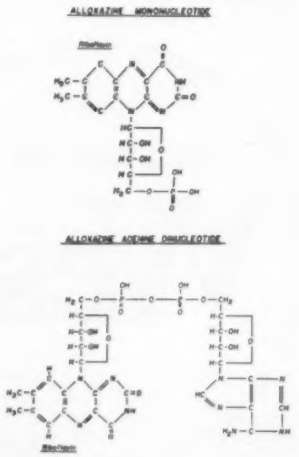


Figure 5.

turn our attention to the enzymes concerned with the carbon portion of the molecule.

Thiamin forms a part of a prosthetic group, cocarboxylase (Fig. 6), which

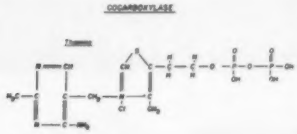


Figure 6.

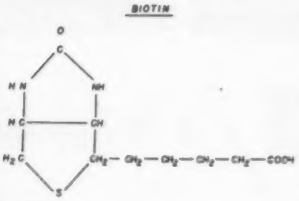


Figure 7.

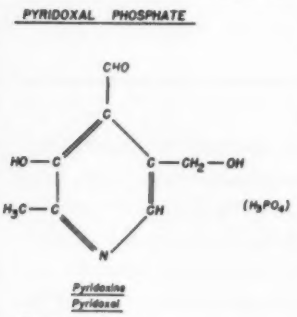


Figure 8.

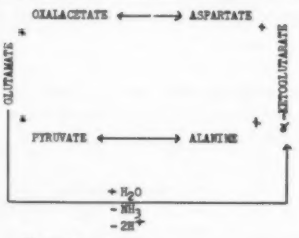


Figure 9.

in conjunction with its protein partner catalyzes the reactions which give rise to carbon dioxide in the steps of the citric acid cycle (Fig. 4) involving pyruvate. In this same general area of metabolism another member of the B-complex, *biotin* (Fig. 7), is also believed to play an important rôle, although the details are not yet clearly resolved.

Pyridoxine is the prosthetic group or coenzyme (Fig. 8) for the enzyme transaminase. This enzyme provides a link between protein and carbohydrate metabolism. A schema of the reactions catalyzed is shown in Figure 9, and by referring to this figure and to Figure 4 it can be seen that there is a ready interconversion between the amino acids and the keto-acids which are intermediates in the cycle. Thus, a mechanism is provided for the oxidation of protein. Pyridoxine apparently has other functions concerned with the oxidation of tryptophane and the decarboxylation of amino acids in general.

Pantothenic acid, combined with other moieties, makes up the structure of the recently discovered Coenzyme A. As may be seen from Figure 10 our knowledge of the structure of this molecule is still incomplete. There is little doubt, however, that the reactions catalyzed by the enzymes which utilize Coenzyme A as a prosthetic group are acetylations. Some examples are: (1) the condensation of "active" acetate

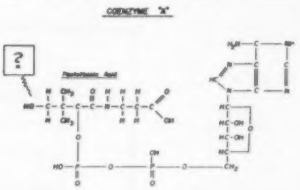
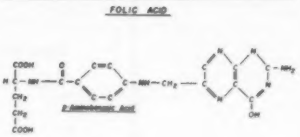


Figure 10.



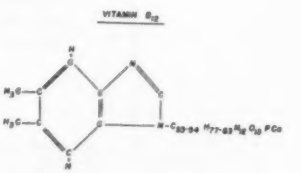


Figure 11.

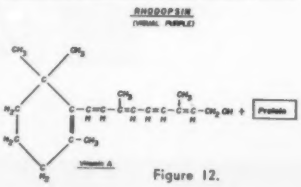


Figure 12.

℞

Completely fulfills every Carbohydrate requirement!

KARO SYRUP IS A PERFECT CARBOHYDRATE ... A MIXTURE OF DEXTRINS, MALTOSE AND DEXTROSE

FOR INFANT FEEDING—physicians have prescribed KARO® Syrup for 30 years, recognizing it as an ideal milk modifier. For all types of formulas . . . for all infants; well or sick.

FOR HIGH CARBOHYDRATE FEEDING KARO, being a mixture of dextrins, maltose and dextrose, can be given in larger amounts than any single sugar.

IN GERIATRICS carbohydrates fill an important function. KARO Syrup is easily digested, well tolerated . . . resistant to intestinal fermentation. It is completely absorbed and utilized.

Medical Division:

CORN PRODUCTS REFINING COMPANY · 17 BATTERY PLACE, NEW YORK 4, N. Y.

P. S. KARO *Syrup is readily available in case lots, from any food wholesaler.*

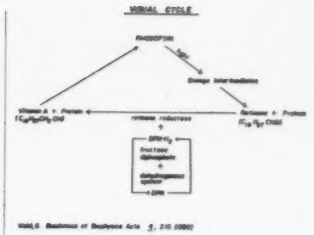


Figure 13.

(Fig. 4) and oxalacetate to form citric acid; (2) the formation of acetylocholine presumably from choline and "active" acetate, and (3) the detoxification reactions such as the acetylation of the sulfonamides.

Folic acid and Vitamin B_{12}, which have been shown to play an important rôle in the prevention and treatment of anemias, are shown in Figure 11. Here the details of structure and mode of action are still in the process of elucidation and are very incomplete. It appears that both substances are active in processes of methylation and perhaps in other synthetic reactions.

Vitamin A (Fig. 12), a complex alcohol, in combination with a protein in the retina forms rhodopsin which is reversibly oxidized and reduced during the visual process. This series of reactions is sketched in Figure 13. In working out this cycle Wald actually employed three vitamins: nicotinic acid in the DPN, Vitamin A in the rhodopsin, and Vitamin E to prevent auto-oxidation of the visual purple. Here, then, is an explanation for the known effect of Vitamin A on vision. The other deficiency symptoms are still not explicable in like terms.

Little is known about the mode of action of the other vitamins. *Vitamin E* is an effective antioxidant and may have some relation to lipid metabolism. *Vitamin K* plays a rôle in the synthesis of prothrombin in the liver. *Vitamin D* is concerned with calcium and phosphate metabolism. *Inositol, ascorbic acid,* and other less well-established compounds are still unknowns with regard to the detailed mechanism by which they mediate their effects.

It is apparent that large gaps still remain in our understanding of the reasons why vitamins are so essential. The conclusion is clear, however, that those *vitamins* about which we have sufficient information function as parts of those catalysts, *the enzymes,* which mediate the vital reactions of cellular metabolism.—JAMES A. BAIN, PH.D.

SHAMPAINE HOWELL O. B. TABLE

• *With...*
COMPLETELY TELESCOPING LEG SECTION

Important Modern Features at Reasonable Cost...

• **THE S-2636 HOWELL O. B. TABLE** offers a one-piece top with a leg section that telescopes completely out of the way and into the body section when the patient is ready for delivery.

It provides the latest modern features found in the more-expensive pedestal-type tables and represents a considerable saving where a fixed tabletop height of 33 inches is satisfactory for all deliveries.

Hand wheel on either side, operating a gear mechanism, quickly adjusts the top from horizontal to Trendelenberg or reverse Trendelenberg positions. The shape of the tubular frame permits ample foot room all around the table.

Consult your dealer at once to investigate this remarkable new Shampaine table, or write for catalog today.

SHAMPAINE CO. *Sold Through Surgical and Hospital Supply Dealers*
SAINT LOUIS • MISSOURI

Conducted by Mary P. Huddleson

The Dietitian Dishes Up Good Will

ELIZABETH A. COLE
Director
Dietary Department
Mountainside Hospital
Montclair, N.J.

FOOD is one of the principal criteria by which patients and personnel judge the service of a hospital. It is therefore one of the most important public relations factors. Mountainside Hospital, Montclair, N.J., has a bed capacity of 366. The staff of dietitians, including the director of the department, administrative dietitian, clinic and teaching dietitian, cafeteria dietitian, and four contact dietitians, numbers eight.

DIETITIAN VISITS PATIENTS

Patients are visited daily by dietitians who also act in a dual rôle as public relations agents. They assist the patient in selecting his menu for the following day; they explain dietary needs, both for special diets and regular diets, and they ask the patients for suggestions concerning the palatability of the food, temperature of the food, variety in the menu, attractiveness of the tray, and so on. Patients frequently write messages on their menus so the dietitians will read them when collecting the menus. The messages read somewhat as follows: "I'm going home. Thank you for the lovely meals"; "congratulations on your very fine meals"; "must say that the variety and flavor of Mountainside food merits praise and thanks"; "before I leave, I want to tell you how much I have enjoyed your meals, and the trays were always attractive."

An article was published recently in the local newspaper, explaining to the public the value of these letters and messages which contain both compliments and (sometimes) complaints. Various services have been improved as a result of such constructive criticism from former patients. Publicity in the local newspaper has been a great aid in building good will in the community. An article appeared under the title "They Serve the Town" about the director of the dietary department, telling of her qualifications and her past experiences in hospitals. Another newspaper article about the dietary department explained the master menu, the number of meals served, the manner in which the food is transported from the main kitchen to the patient, and hospital food costs.

Radio has helped materially in local publicity. The Montclair Public Library sponsored a Thanksgiving program, in which the director of the dietary department was asked to participate by telling about the Thanksgiving dinner to be served at the hospital. One of the selective menu items mentioned on that program was vanilla ice cream with hot mincemeat sauce. The radio talk also emphasized the efforts made to make the personnel feel at home on a holiday. Many employes have been heard to say—"what we miss most, in not being able to be at home, is picking the turkey bones." At this hospital, in addition to a regular holiday supper, a tray garnished with watercress and filled with leftover turkey is placed on the counter with a note, "Make yourselves at home. Please have a turkey bone."

Mountainside Hospital celebrated its sixtieth anniversary by serving an old-fashioned barbecue to 600 people. The dietary department played a large part in this celebration by planning the work schedules, preparing the food, and supervising the serving. It also baked and decorated an anniversary cake which weighed 160 pounds and measured 28 inches in diameter at its base. The meat was provided from a barbecue pit just outside a huge tent which housed tables, chairs and an entertainment platform.

Good will is extended throughout the community by occasionally inviting the various service clubs to have luncheon at the hospital. This gives the members the opportunity of making a tour through the hospital. Such clubs as Rotary, Kiwanis, Lions, Business and Professional Women, and also the Ministerial Association have accepted this invitation.

The members of the medical staff conference who meet at noon once a month have been invited to have luncheon at the hospital. The attendance has increased at these meetings since the invitation has been extended to them.

The Associated Physicians of Montclair and vicinity meet once a month. At one time the group hired a caterer to supply refreshments for its meetings, but the dietary department has been serving the refreshments during the past several years.

TRAINED RED CROSS AIDES

During World War II, the dietary department trained 195 Red Cross dietitian's aides. A large number of these are now members of the women's auxiliary, many of whom formerly had no particular interest in the hospital, but are now holding major offices. Tours for the public are conducted through the hospital each month by members of the women's auxiliary, who have been trained as guides. The dietary department is one of the points of interest included in the tour. In the main kitchen they explain the use of the electric food trucks, the steamers, mixer, potato peeler, and tell the number of pounds of meat used weekly, for example. They explain the cafeteria setup, the correct tempera-

ture of wash and rinse waters in the dishwashing and glasswashing machines. They tour one of the eight floor kitchens, explaining that these are supervised by the dietitians who also visit the patients. They also tell about the nutrition clinic, the teaching of normal nutrition and diet therapy to student nurses. They also mention various other duties performed in the department, such as planning menus, hiring employes, forming departmental policies, and controlling food costs.

Members of the dietary department offer their services to the community in many ways. Recently, the director of the department was consulted by one of the prominent men in the vicinity for advice on the organization and management of a cafeteria. The department frequently helps committees from the local churches by preparing food in the hospital kitchen for church suppers when the necessary equipment is not available in the church.

The clinic dietitian is also active in the community. She teaches nutrition to the mothers' classes and works closely with such local agencies as the Red Cross and visiting nurse service.

Members of the women's auxiliary provide favors for the patients' holiday trays and decorations for the personnel cafeteria on various holidays. The Girl Scouts also frequently make favors for patients' trays.

One does not fully realize the potential value and the importance of the dietary department in building community good will for the hospital until the results are enumerated as they are in this paper.

Incidentally, building good will in the community makes the duties of the dietitian far more interesting and encourages her to make even greater efforts in satisfying the patients, especially since so many of them have become her friends through the cordial relations developed in the community.

SPECIALS show a profit

in the employes' cafeteria

CLARA MEYER
Dietary Manager
Bay City General Hospital
Bay City, Mich.

THE new employe cafeteria at Bay City General Hospital, Bay City, Mich., "paid off" $1287 during its first month of operation—at an installation cost of $345 and no new employes.

During January 1951 our city commissioners accepted and put into operation a plan for financial reorganization of the hospital which included the instruction that all employes must pay for their meals beginning February 1. So, when another tradition was broken by the announcement that I would have to set up a cafeteria pay system, I just heaved a deep sigh, shook my head, and believed the administrator when he said "We can do it—even if we don't have very much time to prepare for it." (I still suspect that he had this in mind all the time when he had our hospital carpenter build a new "self-service food serving counter" several months ago.)

At the beginning of our planning for this service, we anticipated that many employes might resent paying for their meals after having them "free" for so many years. Therefore, we organized on the supposition that approximately one-third of the regular staff of more than 200 employes would bring their sandwiches, apples and coffee jugs from home for their daily meal. To encourage their use of our service for hot meals, we had already established "Coffee-Free" 24 hours of every day for all employes—during

SPECIAL:	
Short Ribs	15c
Roast Veal	15c
Roast Pork	15c
Roast Beef	15c
Roast Lamb	15c
Liver	15c
Baked Ham	15c
Broiled Fish	15c
Meat Pie	25c
Beef Stew	20c
Hamburger	20c
SALADS:	
Vegetable	12c
Fruit	15c
HOSPITAL BAKED PASTRY—EVERY DAY	
Cake	7c
Pie	9c
Pudding	
Shortcake	11c

REGULAR Sandwiches, such as:	
Cheese	20c
Ham	25c
Hot Beef	30c
Tomato	20c
& Bacon	28c
Egg Salad	15c
Ham Salad	20c
REGULAR Soups	10c
Chili	15c
COOKED VEGETABLES	8c
Potato	5c
ICE CREAM	7c
MILK (brown or white)	8c
Tea	FREE

COFFEE—FREE

Hobart's Best Ads are its Products ...IN USE!

Our ads can only *tell* you—all our products *show* you through performance. And don't forget—every day, Hobart's unrivalled nation-wide service becomes more valuable to you, too! Get in touch today with Hobart, and the most complete line of quality food, kitchen and bakery machines in the business.

Trade Mark of Quality for over 50 years

Hobart *Food Machines*

THE HOBART MANUFACTURING COMPANY • TROY, OHIO

The World's Largest Manufacturer of Food, Kitchen and Bakery Machines

meals, or during their two 10 minute rest periods on each duty. We were not far wrong in our estimate, because during our first 28 days of operation we served an average of 143 employes per day, or about two-thirds of the regular employes (practical nurse students still receive their meals free). The number of employes paying for their meals is increasing daily, however, but their average payment per meal remains constant, at $0.32 per meal.

For that $0.32 they have their choice of a continually changing variety of foods, such as those shown in the list on page 116.

The medical staff members have reacted most favorably to the cafeteria system, and line up in increasing numbers. Before our present system, they seemed to be embarrassed about accepting "free" meals; now, they feel that they are contributing to our finances while privileged to get good meals cheaper. Even their executive and special committee meetings are preceded by their presence in the "chow-line."

Unfortunately, we cannot invite hospital visitors to eat with us for the city commission specifically designated that the cafeteria is to be conducted for the employes, with prices to be "as near actual cost as possible," in anticipation of returning an estimated $21,900 per year partially to offset the more than $100,000 annual increase in salaries.

In estimating our costs, we have considered the actual cost of the food used by determining the number of servings possible per unit purchased and adding 33⅓ per cent over-all processing, preparation and serving charge. The only new equipment cost was for a cash register and a large menu board with 1 inch plastic letters and numerals. No additional employes were needed because one of our counter servers had had extensive restaurant cashiering experience. I check out the main cashier once every 24 hours (after she has checked out the 1:30 a.m. and 7 a.m. cashiers), and for many weeks we have never been over or under on our cash transactions.

A simple but effective system is used to keep our finances in order with the administrative office cashier, and we feel that we are contributing to the financing of our active small hospital, which accommodates 154 adult patients and 33 bassinets.

DESIGN OF ALL-PURPOSE SINK

MARY deGARMO BRYAN
Head, Institution Management
Teachers College, Columbia University

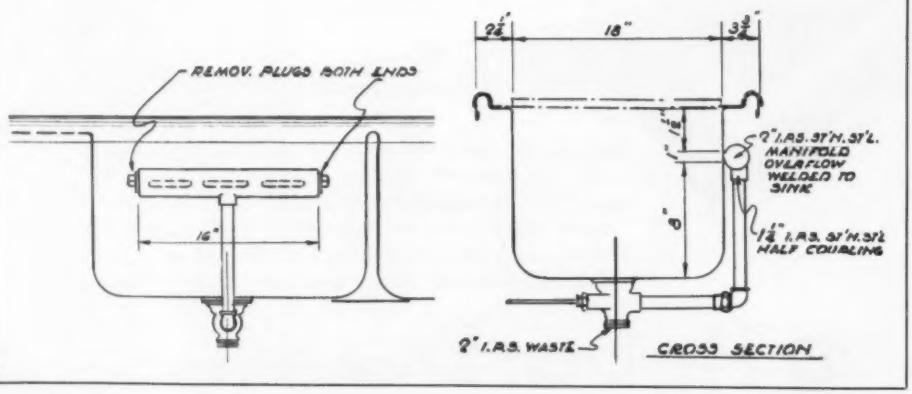
OWEN WEBBER
Consulting Engineer
New York City

THIS three-compartment sink may be used for vegetable and salad preparation, and for pot washing also, in institutional kitchens. It is shallow—9 or 10 inches deep—and may be fabricated by welding drawer compartments of standard size into the drainboard. Each compartment, 18 inches from front to back and 24 inches long, is adequate for washing pots and pans used in the kitchens.

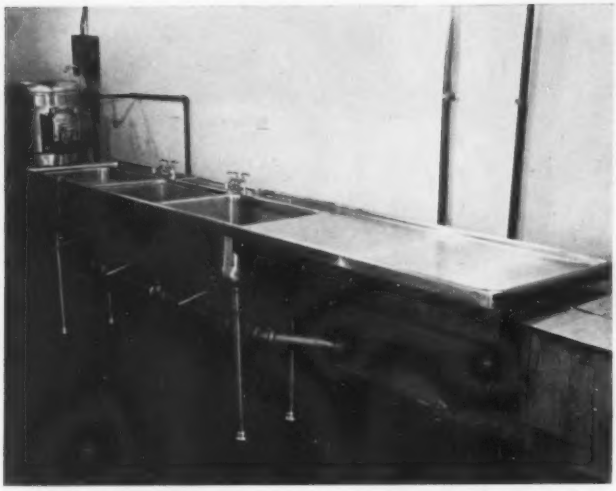
Swing faucets mounted between compartments leave the work areas clear. The sink may be made without a splashback and if set away from the wall can be used from both sides. Drainboards may be of any desired length. A peeler may be set so as to empty on to the left-hand drainboard, or the board may be omitted so that the peeler empties directly into the first compartment.

A wire basket such as is used in a family size fry kettle may be used as a container for holding eyes of potatoes

COMBINATION POT WASHING & VEGETABLE SINK
(WITH SLOTTED MANIFOLD TYPE OVERFLOW)




Hospitals especially require
More Coffee Flavor
Yes—MORE coffee flavor, because the heaviest users of coffee in every hospital are keen, critical judges of good coffee. They are your staff members. Please these discriminating people and there is never a doubt about pleasing your patients.
Flavor . . . deeper, richer, more pronounced coffee flavor . . . coupled with full body and uniformity of brew is Continental's outstanding quality characteristic. Flavor . . . More Coffee Flavor . . . has established Continental as America's leading coffee for restaurant and institutional service.
Try Continental yourself! Ask your Continental man for a free trial package—or write direct.
YOU'RE SURE TO PLEASE YOUR PATIENTS
WHEN YOU PLEASE YOUR STAFF
ONE POUND NET
CONTINENTAL
WB BLEND
COFFEE
Continental Coffee
AMERICA'S LEADING COFFEE for RESTAURANTS, HOTELS AND INSTITUTIONS
CONTINENTAL COFFEE COMPANY—CHICAGO 90, ILL.
BROOKLYN 1, N. Y. • TOLEDO 1, OHIO
Importers, Roasters Member: New York Coffee and Sugar Exchange, Inc
MAKERS OF CONTINENTAL'S "76" MENU PRODUCTS

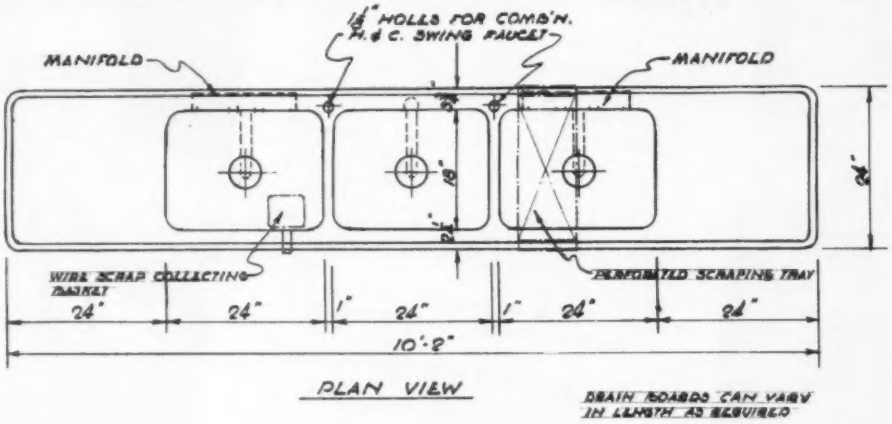


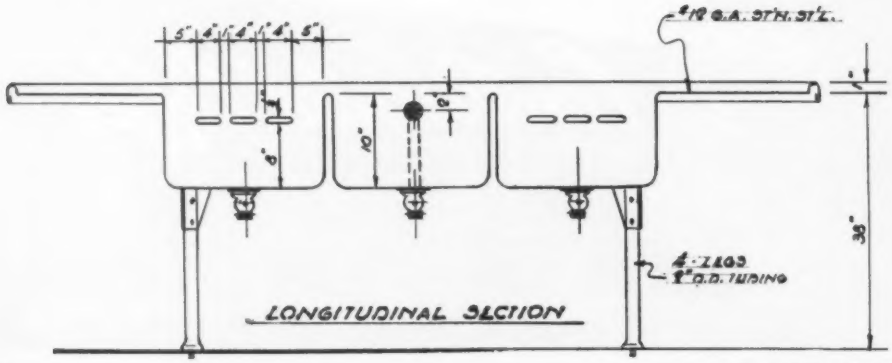
This three-compartment vegetable sink has been made without a back as it will be so placed in its new location that it can be used from both sides.

and vegetable trimmings if the handle is bent so as to hook the basket on the edge of the compartment. A removable, perforated, shallow stainless steel tray may be placed across one end of the compartment used for soaking when the sink is used for pot washing. Pots are scraped into this tray, washed in clean soapy water in the adjoining compartment, and rinsed in very hot water in the third.

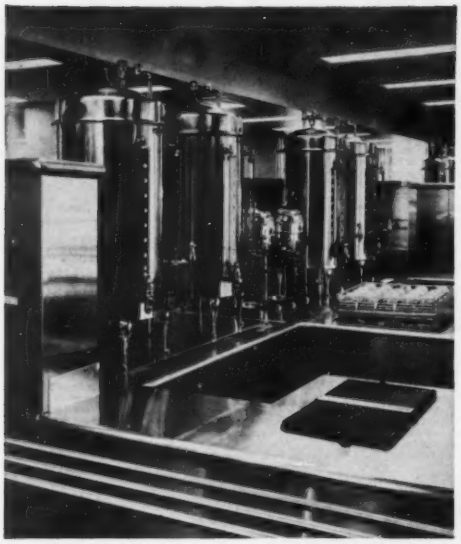
A stainless steel wire basket (not illustrated), electrically welded, with handles on the left side should be made to fit one of these compartments. It is used to avoid multiple handling of pots or vegetables.

The entire unit is constructed with marine rolled edge on all sides with rounded corners. Sinks are fully coved with slot overflows on two compartments and standard overflow on the center compartment and have lever handled waste outlets. The sinks are mounted 38 inches high on stainless steel pipe legs with adjustable feet.



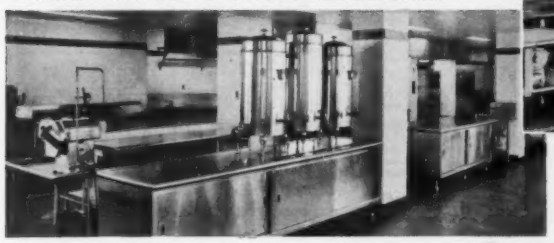


award winners prefer *TRI-SAVER* coffee urns



MUTUAL LIFE INSURANCE COMPANY, NEW YORK
First Award **— Close-up of cafeteria counters showing coffee urn stations, employees' cafeteria. Note Tri-Saver combination urns.**

WILSON MEMORIAL HOSPITAL, Johnson City, New York
Merit Award **— Note the Tri-Saver three-piece battery on stainless steel stand — main kitchen. Coffee urns are also of stainless steel.**

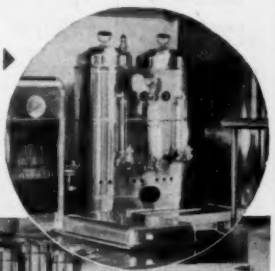


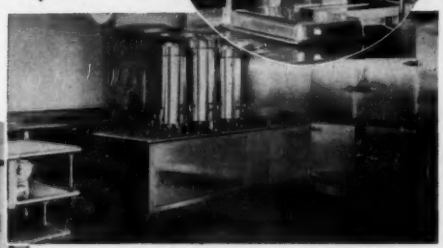
Institutions Contest winners eliminate urn bags and filter paper with Blickman TRI-SAVER system.

● Where coffee brewing demands are heavy — where reliable service is a necessity — experienced operators insist on Tri-Saver coffee urns. Here are shown some of the Tri-Saver installations among this year's Institutions Magazine Food Service Contest winners. Proven performance in providing a *uniformly rich, flavorful brew* and *elimination of urn bags or filter paper* — were important factors in the selection of this equipment. Let the experience of these prominent institutions guide you. Specify Tri-Saver for your new coffee making equipment.

BAYLOR HOSPITAL, Dallas, Tex.
Merit Award **— Note space-saving Tri-Saver stainless steel twin urn in floor pantry.**

STATLER HALL, CORNELL UNIVERSITY, Ithaca, New York.
Honor Award **— Stainless steel 3-piece Tri-Saver battery and urn stand — main kitchen.**





This permanent stainless steel Tri-Saver filter eliminates urn bags and filter paper. A quick rinse cleans filter. Coffee grounds cannot clog it.

OTHER 1951 AWARD WINNERS USING TRI-SAVER URNS

Northern Indiana Children's Hospital, South Bend	Honor Award
Weldon Cafeteria, Houston, Texas	Merit Award
Burdine's, Inc., Miami, Florida	Merit Award
M. K. Goetz Brewing Co., St. Joseph, Mo.	Honor Award
Agnes Scott College, Decatur, Georgia	Merit Award

Send for Tri-Saver book **— gives full story of Tri-Saver Coffee System. Shows complete line of single urns, batteries, twin, combination and institution urns in capacities from 3 to 80 gallons. Available for gas, steam or electric heat.**

S. BLICKMAN, INC., 150P Gregory Ave., Weehawken, N. J.
New England Branch: 845 Park Square Bldg., Boston 16, Mass.

Blickman-Built
FOOD SERVICE EQUIPMENT

Your are welcome to our exhibit at the American Hospital Association Convention, Kiel Auditorium, St. Louis, Missouri, Booths No. 1414-16-18-20, September 17 to 20.

Menus for September 1951

Mildred Schlafer
Glenville Hospital
Cleveland

1 Grapefruit Sections Bacon • Barley Broth Roast Lamb, Mint Jelly Duchess Potato Lemon Glazed Carrots Chocolate Spanish Cream • Cream of Spinach Soup Creamed Chipped Beef, Mushrooms in Toast Cup Baked Acorn Squash Cinnamon Apple Salad Fresh Peach Shortcake Whipped Cream	**2** Honeydew Melon, Lemon Pecan Roll • Boysenberry Nectar Roast Turkey Cranberry Sauce Mashed Potato, Gravy Frozen Peas Lettuce, 1000 Is. Dressing Vanilla Ice Cream • Cream of Chicken Soup Tomato, Bacon Grill, Cheese Sauce Frozen Asparagus Spears Molded Perfection Salad, Mayonnaise Baked Custard Creme	**3** Frozen Blueberries Scrambled Eggs, Jelly • Beef Vegetable Soup Baked Virginia Ham Escalloped Sweet Potato, Apples Cauliflower Relish Plate Fresh Fruit Cup • Cream of Mushroom Soup Chicken Salad, Toasted Almonds Baked Stuffed Potato Stuffed Olives Spiced Crabapple Angel Food Cake	**4** Stewed Apricots Little Pig Sausage • Turkey Noodle Soup Broiled Liver Creamed Potato Frozen Lima Beans Prune Whip, Custard Sauce • Cream of Vegetable Soup Tunafish, Potato Chip Casserole Frozen Broccoli Spears Sliced Cranberry Jelly, Grapefruit Salad, French Dressing Chocolate Chip Ice Cream	**5** Bananas Poached Egg • Turtle Soup Chicken Fricassee Mashed Potato Baked Acorn Squash Baked Date-Nut Pudding, Whipped Cream • Cream of Tomato Soup Breaded Sweetbreads, Mushrooms Buttered Brown Rice Molded Cheese Salad Frozen Strawberries Vanilla Wafers	**6** Fresh Sliced Peaches Bacon • Chicken Rice Soup Pot Roast, Gravy Brown Potato Fresh Wax Beans Butterscotch Pudding, Toasted Cocoanut • Cream of Celery Soup Ham, Sweet Potato, Apple Casserole Frozen Asparagus Spears Tossed Salad, French Dressing Cup Cake
7 Fresh Orange Juice Crumb Kuchen, Jelly • Clam Chowder Haddock, Tartare Sauce Escalloped Potato Diced Carrots Lemon Sponge Cup • Cream of Pea Soup Cheese Soufflé, Spanish Sauce Frozen Spinach Melon Ball Salad, Fruit French Dressing Chocolate Ice Cream With Marshmallow Sauce	**8** Cantaloupe Scrambled Eggs • Creole Soup Broiled Veal Cutlet Creamed Hashed Potato Cinnamon Beets Pineapple Snow Custard Sauce • Cream of Potato Soup Dutch Chicken Loaf, Relish Potato Salad Celery, Carrots Spiced Prune Bavarian Cream	**9** Frozen Strawberries Little Pig Sausage • Apricot Nectar Roast Chicken Mashed Potato Frozen Corn Celery Cabbage, 1000 Is. Dressing Vanilla Ice Cream • Vegetable Noodle Soup Shrimp Salad Tomato Wedges, Gherkins Spiced Pineapple Slices Baked Stuffed Potato Apple Crisp With Custard Sauce	**10** Fresh Plums Poached Egg • Chicken Gumbo Soup Broiled Cube Steak French Fried Potato Frozen Peas Pineapple Graham Cracker Pudding • Cream of Carrot Soup Ham, Asparagus Roll, Cheese Sauce Baked Crumb Noodles Molded Bing Cherries, Nut Salad in Lime Gelatin Orange Ambrosia	**11** Baked Apple Bacon • Scotch Broth Chicken à la King Oriental Noodles Fresh Broccoli Strawberry Ice Cream • Cream of Corn Soup Beef Patty Sweet Potato Puff Lettuce Salad Russian Dressing Floating Island	**12** Orange Juice Soft Cooked Egg • Cooperstown Soup Broiled Ham Slices Pineapple Rings Potato au Gratin Succotash Apricot Bavarian • Cream of Asparagus Soup Liver Casserole Baked Hubbard Squash Prune, Orange Salad Honey Dressing Baked Chocolate Nut Pudding, Whipped Cream
13 Stewed Fruit Compote Bacon • Chicken Rice Soup Meat Loaf, Gravy Mashed Potato Fresh Green Beans Snow Cake • Cream of Pea Soup Baked Stuffed Mushrooms Braised Celery Sliced Beets Deviled Egg Salad Orange Sherbet	**14** Pineapple Tidbits Sweet Roll • Potato Chowder Baked Halibut, Tartare Sauce Marmalade Sweet Potato Cauliflower Lemon Mist • Cream of Spinach Soup Spaghetti, Tomato, Cheese Casserole Frozen Broccoli Spears Molded Cranberry Salad Vanilla Ice Box Pudding	**15** Honeydew Melon, Lime Omelet, Jelly • Potage Velour Soup Roast Lamb, Mint Sauce Creamed Potato Frozen Asparagus Spears Green Gage Plums • Oyster Bisque Stuffed Pepper Parslied Baked Carrots Banana, Nut Salad, Mayonnaise Pineapple Bread Pudding	**16** Grapefruit, Orange Bacon • Melon Balls in Gingerale Roast Rabbit, Gravy Mashed Potato Frozen Lima Beans Relish Plate Vanilla Ice Cream • Cream of Vegetable Soup Cold Red Salmon, Lemon Sliced Tomato, Olives Spiced Apple Slices Date, Nut, Cream Cheese Sandwiches	**17** Tomato Juice Scrambled Eggs, Jelly • Mulligatawny Soup Roast Beef Ribs, Gravy Duchess Potato Frozen Mixed Vegetables Royal Anne Cherries Cookies • Cream of Corn Soup Chicken Noodle Casserole Fresh Green Beans Cinnamon Apple Salad, Honey Dressing Cocoanut Spanish Cream	**18** Stewed Prunes Little Pig Sausage • Beef Noodle Soup Broiled Veal Cutlet Mashed Potato Orange Beets Peach Crisp, Hard Sauce • Cream of Mushroom Soup Italian Spaghetti and Meat Balls Chef's Salad Bowl, French Dressing Frozen Strawberries Whipped Cream, Cookies
19 Bananas Apple Kuchen • Turtle Soup Chicken Chop Suey Buttered Rice Baked Acorn Squash Orange Sherbet • Oyster Stew Baked Potato Cottage Cheese Large Fresh Fruit Salad, French Dressing Graham Cracker, Marshmallow Custard	**20** Fresh Orange Juice Bacon • Chicken Barley Broth Broiled Liver Escalloped Potato Carrots, Celery Heavenly Hash • Cream of Pea Soup Dried Beef Soufflé, Mushroom Sauce Frozen Asparagus Spears Fig Cheese Salad Buttercup Dressing Sponge Cake	**21** Fresh Sliced Peaches Poached Egg, Jelly • Clam Chowder Haddock, Tartare Sauce French Fried Potato Broccoli Apricot Bavarian • Cream of Potato Soup Broiled Tomato Frozen Lima Beans Mashed Squash Panama Salad, French Dressing Baked Custard, Fruit Sauce	**22** Fresh Applesauce Little Pig Sausage • Soup Supreme Salisbury Steak Parslied Buttered Potato Cauliflower Mocha Soufflé • Cream of Spinach Soup Sweetbread, Green Bean, Mushroom Casserole Baked Sweet Potato Molded Vegetable Salad, Mayonnaise Fresh Fruit Cup Cookies	**23** Persian Melon Sweet Roll • Loganberry Nectar Roast Turkey Cranberry Sauce Mashed Potato, Gravy Frozen Peas Relish Plate Strawberry Ice Cream • Cream of Chicken Soup Ham, Egg Salad Baked Stuffed Potato Sliced Tomato Spiced Pear Apple Brown Betty, Hard Sauce	**24** Pineapple Juice Bacon • Tomato Bouillon Roast Lamb, Mint Jelly Creamed Potato Fresh Wax Beans Date, Cocoanut, Marshmallow Pudding • Cream of Asparagus Soup Tuna Soufflé Buttered Diced Beets Banana, Orange Salad, French Dressing Fruit Gelatin, Whipped Cream
25 Stewed Peaches Soft Cooked Egg • Turtle Soup Baked Ham, Raisin Sauce Browned Potato Frozen Spinach Vanilla Ice Cream • Cream of Mushroom Soup Grilled Tomato, Minced Chicken Topping Frozen Broccoli Spears Frozen Corn Blushing Pear Salad, Honey Dressing Pumpkin Chiffon Pudding	**26** Fresh Orange Juice Bacon • Turkey Rice Soup Broiled Cube Steak Escalloped Potato Baked Hubbard Squash Green Gage Plums • Cream of Carrot Soup Baked Macaroni and Cheese Frozen Lima Beans Apple, Celery, Grape, Marshmallow Salad Angel Food Cake	**27** Grapefruit Sections Scrambled Eggs, Jelly • Old Fashioned Velvet Soup Creamed Chicken, Mushrooms Mashed Potato Fresh Green Beans Butterscotch Tapioca Pudding, Whipped Cream • Cream of Potato Soup Porcupine Meat Balls Frozen Asparagus Spears Molded Perfection Salad, Mayonnaise Coffee Ice Cream	**28** Honeydew Melon, Lemon Butternut Kuchen • Vegetable Chowder Baked Salmon, Tartare Sauce Potato au Gratin Harvard Beets Lime Cream Dessert • Cream of Tomato Soup Fresh Peas, Eggs and Cheese Casserole on Oriental Noodles Relish Plate Baked Chocolate Nut Pudding, Whipped Cream	**29** Tangerine Juice Bacon • Scotch Broth Pot Roast, Gravy Browned Potato Parslied Baked Carrots Cup Cakes • Cream of Spinach Soup Ham, Rice Casserole Frozen Peas Molded Cranberry Salad, Mayonnaise Baked Custard	**30** Baked Pears Little Pig Sausage • Grape Juice Cocktail Roast Chicken, Gravy Mashed Potato Frozen Asparagus Spears Lettuce, 1000 Is. Dressing Vanilla Ice Cream • Vegetable Soup Toasted Tomato and Bacon Sandwich Olives, Spiced Prune Fresh Fruit Salad Bowl, Fruit French Dressing Chocolate Chiffon Pudding

Ready-to-eat or cooked cereals are offered on all breakfast menus.

COLOR adds ~~Beauty~~ Business

BOLTA adds *Color*

with BOLTABEST Laminated Trays in 5 Modern Textural Patterns each in 6 Decorator Colors

Like the frosting on the cake, Boltabest Laminated Color-Trays add the color, beauty, and "finishing touch" that makes every well-served or self-served meal more appetizing. Produced in thirty different combinations of colors and patterns to meet every decorative possibility, you can *match* Boltabest Color-Trays to your counter or table tops, *contrast* them with your other furnishings; or, *introduce* an altogether *new* color effect . . . for here is a tray that does its job better and longer than any other, with the added asset of colorful customer-appeal. And it costs so little extra, just a few cents more a tray.

For full color-range and price information, write us at once or see your own dealer.

Only BOLTA has perfected the techniques that make possible this combination of laminated patterned color and outstanding durability.

- In sizes 12x16, 14x18 and 15x20.
- Non-porous, Satin-smooth Surfaces
- Impervious to Cigarette Burns, Food Acids, Alcohol and Fruit Juices
- Lightweight, Noiseless, Easy to Handle
- Washable in Mechanical Dishwashers
- Will Not Break, Warp, Fade, Spot or Split

Priced far lower than you would expect.

Also Famous Boltalite Hard Rubber Trays in Sizes 10x14, 12x16, 14x18 and 15x20. Also Boltabilt Trays in Round, Oblong and Oval Shapes, in 15 different Sizes.

The **BOLTA** *Company*
LAWRENCE
MASSACHUSETTS

Planning for Maintenance Control

GEORGE BLUMENAUER
Architect and Hospital Consultant
Kansas City, Mo.

A PENNY saved is still a penny earned, and sometimes this truth is formidable. Once a hospital is built, a serious phase of its existence, including maintenance, begins. Costs for maintenance accumulate progressively and are a substantial percentage of the gross annual expense. They may be delayed but not avoided while a project continues to operate, although in some degree they may be controlled.

Maintenance and obsolescence[1] are related but are in different categories. Maintenance applies to a property in its physical sense, while obsolescence is economic. Maintenance falls into two main divisions and comprises the costs for repairs, upkeep and replacements of (1) the structure of the building or buildings, fixed equipment, and grounds and (2) the furnishings and movable equipment. This article refers primarily to the first division. A sizable book would be needed to explain the many items and inconstant factors related to maintenance.

Many hospitals have been erected during recent years; others are contemplated. Many newly organized owners will soon begin experiencing the demands of maintenance relative to their projects. Many administrators of long experience attest the potential worth of "planned and preventive" maintenance. The accumulated result of experience in this field is of value to owners who will obtain and analyze it; it may help to point out what to avoid and may show comparative methods of operation. (For example, there are wrong methods and good methods of dealing with routine problems, such as care of floor surfaces.[2]) Table 1 relates to six general hospitals in the Kansas and Missouri area and shows the approximate portion of gross annual expense in the year 1950 which each expended for maintenance and repairs.

Table 1—Portion of Gross Annual Expense Required for Maintenance in Six General Hospitals, 1950

TYPE OF GENERAL HOSPITAL	NUMBER OF BEDS	TOTAL OVER-ALL BUDGET	MAINTENANCE AND REPAIRS	PER CENT	PER PATIENT DAY
1. Church	375	$1,596,316.39	$45,639.35	2.86	$0.376
2. City	269	550,000.00	35,000.00	6.38	0.470
3. University (state)	460	1,260,865.74	82,119.96	6.52	0.609
4. Church	130	644,425.59	9,841.87	1.50	0.235
5. City	550	1,450,000.00	70,000.00	4.83	0.486
6. Church	150	661,270.79	42,340.32*	6.40	0.910
MEDIAN				4.75	$0.514

*Approximately $10,000 of this sum results from an accrual of $30,000 in deferred maintenance.

These percentages taken individually do not in all ways reflect identical on-the-job conditions. Some of the projects are subject to more intensive use than others, and some show evidence of better maintenance than others. Some hospitals in the area, not listed in the table, do not separate various subdivisions in their accounting systems, such as supplies, nursing services, maintenance and repairs, and plant operation.

A result of accumulated experience is that maintenance costs may be estimated with fair accuracy, and it undoubtedly is good business to set up a per cent of gross income to accumulate for maintenance. Maintenance costs basically are not constant for every type of project or for varying specification and construction standards, even though the quality of management is equal. The ratio may vary as the construction standards vary; the judgment and skill used by management will have a bearing on the problems and expense entailed in maintenance and mechanical repair programs.

One should not believe that once a project is built and furnished the nature of the investment is permanent. For we no sooner commence to erect a structure than time and the elements begin to destroy it. For practical economic reasons buildings tend to be permanent, but management and operating methods are transitory; obsolescence may destroy the usefulness of an otherwise sound structure. In the process of "use" many matters connected with maintenance and repairs present themselves for evaluation—walls, roofs, floors, doors and windows; painting and decorations; heating, plumbing and electrical installations; hardware; parts of a structure where moisture may infiltrate; equipment and furnishings, and drives, walks, lawns and shrubbery. The foregoing break down into many details and several thousand individual items.

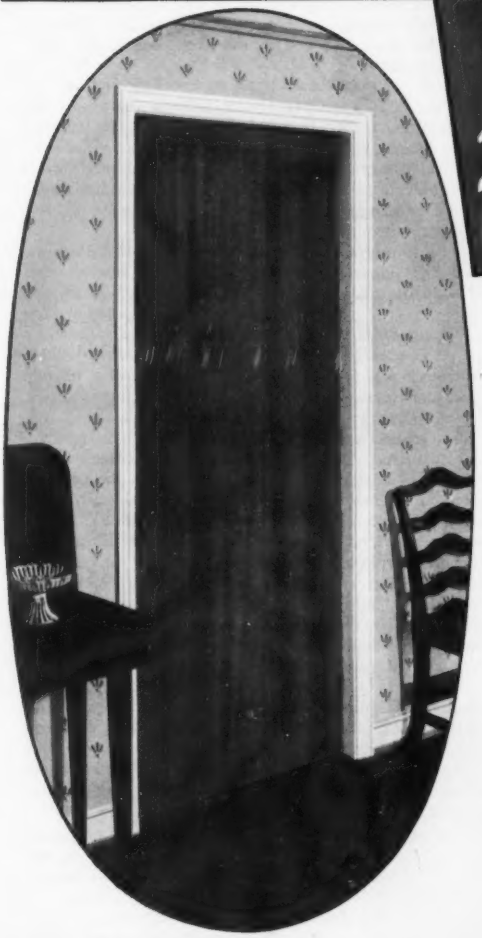
Much can be done to help control future maintenance costs and problems while a project is in the plan and

[1] Obsolescence Problems in Hospitals. Southern Hospitals, August 1948.

[2] Keep the Winter off Your Floors. Hospital Progress, January 1951.

now! MENGEL MAHOGANY *Flush* DOORS

Available at less than many Domestic Woods!



"Believe it or not"!—Mengel Flush Doors with faces of genuine African Mahogany can now be bought for less than comparable doors built with many conventional domestic woods!

Why? Because Mengel, drawing from its own vast logging concessions in the heart of Africa's Gold Coast, brings its fine Mahogany veneers to America in tremendous volume. Second, Mengel has the wood-working equipment and know-how to manufacture its top-quality doors *with mass-production economy and efficiency!*

Use the coupon to get full details about Mengel Mahogany Doors. Until you know the facts, you'll never appreciate the extra luxury, the extra *values* now immediately available for *any* kind of job.

THE MENGEL COMPANY
Plywood Division, Louisville 1, Ky.

Gentlemen: Please send me full information on Mengel Mahogany Flush Doors—Hollow Core and Stabilized Solid Core.

Name_____

Firm_____

Street_____

City_____ State_____

The Mengel Company . . . America's largest manufacturers of hardwood products • growers and processors of timber • manufacturers of fine furniture • veneers • plywood • flush doors • corrugated containers • kitchen cabinets and wall closets

specification stage. While the project is being constructed the quality of control exercised over workmanship, materials and construction methods will have a bearing on the amount of gross income that will be required in the future for maintenance and repairs.

Every part of a building does not deteriorate at an equal rate. Well constructed brick or stone masonry exterior walls may well endure for several centuries, but painted surfaces may need replacement after three to five years of use. When management has the long-term point of view and apportions a part of gross income for maintenance and replacements, the annual budget largely may be spared periodical, heavy demands for funds because of cumulative deferred maintenance.

A hospital may budget the various maintenance and replacement items by estimating their capital cost and the period of service expected of items in the structure, such as is shown in Table 2.

Table 2—Estimated Period of Service of Certain Maintenance and Replacement Items for Budget Purposes

ITEM	YRS. EST. SERVICE
Roofing	20 to 25
Heating (steam or hot water)	30 to 35
Painting and decorating	3 to 5
Floor surfaces	15 upward
Plumbing	25 to 30
Screens, windows	10 to 12
Screen doors	3 to 5

Management's alertness to protect and preserve will have a bearing on the period of service of the building and its equipment. Should budgeted items outlive the expectancy, so much the better!

Maintenance of Foundations. Introduction to future maintenance problems begins when the excavating is started for a structure's foundations. One may think of structural foundations as being set in the "solid" earth, but behavior of soil and rock near the earth's surface is not always predictable. At many prospective building sites will be found soil or rock masses that have a tendency toward slow movement; soil that, below the surface, comprises fine, water saturated sand or water bearing sand or gravel, or a filled-in area comprised of undependable elements. A bed of subsurface clay on sloping strata, with a tendency to slide, is not uncommon.

Thorough preliminary investigation of subsoil conditions, by means of test borings, will provide an additional safeguard for the foundation engineering and is a justifiable expense even on so-called small hospitals. No small part of the structural cracks occurring in buildings or of the damage caused by settlement of foundations is the result of the builder's having inexact data about the nature and character of soil under the structure. Buildings in which such defects appear are encountered in all sections of the country; they may be difficult and costly to repair, often the defects are unsightly, and where they occur in exterior walls they will admit moisture.

Moisture Control. A common source of damage to buildings is moisture penetration[3] into the structure through basement floors, exterior walls and roofs, and about doors and other exterior openings. This defect is observable in many buildings and tends to result in damage to plaster, wall decorations and contents of the structure; where continued over a long period of time moisture penetration may cause structural damage because of corrosion, decay and the disintegrating tendencies caused by alternate freezing and thawing of moisture saturated areas.

If moisture conductive paths through which water may seep into a structure are not sealed off, expense of a recurrent nature for repairs and maintenance of damaged interior surfaces may be expected. When corrections of such defects in completed structures are necessary, they may be difficult and expensive to make and somewhat less than satisfactory. Safeguards against leaking basement floors, exterior walls and roofs and against leaks around exterior openings are best assured as a structure is being built; they will result from proper details and specifications, and suitable materials and workmanship, properly executed.

Maintenance of Mechanical Equipment. A substantial part of the capital cost of a modern hospital is comprised in the plumbing, heating and electrical installations. Maintenance of the mechanical system becomes a substantial item in over-all cost of operation. Piping installations, including conductors for all kinds of liquids and gases, invite corrosion and leaks at joints, valves and connections. There is the probability of dripping from horizontal runs of cold water piping, resulting from condensation where the pipe is not insulated. Electrical installations will require adjustments and repairs periodically.

Accessibility of piping and connections for mechanical equipment will simplify maintenance problems. Often when repairs must be made to piping installations it is necessary to tear out permanent construction to obtain access to the source of trouble, and after the repairs are made the torn-out areas need to be rebuilt. The cost of such operations emphasizes the need for easy accessibility to piping wherever practicable.

The conversant architect naturally will see that corrosion resistive materials and acid resistant waste lines are used in piping installations. Corrosion may develop holes in the piping and permit leaks; the corroding material may accumulate and thus reduce the area and efficiency of the pipe. Maintenance control in the mechanical installation begins at the time of planning and construction.

Maintenance of Exposed Surfaces. Floors, walls, painted surfaces and decorations normally are subject to hard use. In the interests of operating economy such surfaces should withstand a maximum amount of normal wear.

Early this year I visited a recently remodeled hospital of substantial size, in Missouri. Flooring of a thin "roll type" had been laid over the concrete slab in corridors and in many other areas, with the idea that this covering would provide a practical, easily maintained wearing surface. But after only a few months of service this material was showing a need for early replacement.

No one individual wearing surface for floors will meet the requirements of every kind of area in the hospital, but by examining several materials, such as troweled concrete, terrazzo, linoleum, asphalt tile, cork, quarry tile, and, under some conditions, a bituminous surface, the planner can find wearing surfaces to provide maximum amounts of service, requiring only reasonable maintenance.

In the course of normal operations fingerprints, stains and abrasions will occur on the surface of walls. Interior painted and decorated surfaces normally will meet hard wear, and materials should be chosen that will endure a maximum number of cleaning operations. It is merely good business to

[3] Blumenauer, George: Moisture Problems and Control. Mod. Hosp. 76:114 (January) 1951.

choose such materials and methods on a basis of their past, long-term performance. A period of at least five years of successful past-performance is not an unreasonable standard. Usually it is wise to let someone else do the experimenting. There is no magic in any known materials that will render them impervious to normal wear-and-tear. The best to be hoped for is to obtain efficient, esthetically pleasing surfaces and ratably to lessen the depreciation and obsolescence rate.

In areas of hard use, such as kitchens, toilets and bathrooms, stairways, laboratories and utility rooms, a wainscoting laid with tile or terra cotta units having a glazed finish surface at least will require a minimum of maintenance, as compared with most other kinds of surfaces.

Among recurrent maintenance items in hospitals is the need for repainting exposed finish surfaces. The planner ratably can lessen such future expense by selecting and specifying for many purposes materials that have satisfactory wearing or exposed surfaces and may not require painting.

In a choice between different kinds of materials to serve a given purpose a ratable increase of capital investment may be justified if a material of higher unit cost will become a more economical material to use and maintain than a cheaper material. In the hospital the long-term point of view, including labor saving, should be in the foreground of planning.

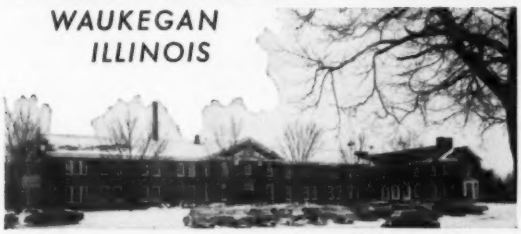
Dust Ledges. Literally thousands of lineal feet of potential dust ledges may become part of permanent construction. Dust ledges are formed by offsetting door or window casing, base, wainscoting caps, the tops of lockers and cabinets, paneled doors and like items. Much labor is required in recurrent cleaning of dust ledges, and damage to adjacent walls and other areas will tend to result from applications of the dust cloth—a recurrent waste of labor and money. Savings in maintenance will result if dust ledges are avoided when a project is being planned.

No satisfactory substitute appears for enduring quality, where this virtue is needed. On the other hand, there seems no practical reason to construct a building to endure for a century when the expected period of use would be for only a comparatively short period of years. In any case a thoughtful balancing of capital cost *vs.* maintenance and repairs is justifiable.

CRANE

the preferred plumbing

AT
VICTORY MEMORIAL HOSPITAL
WAUKEGAN
ILLINOIS



FOR PATIENT'S COMFORT

• All the conveniences and sanitation of America's *preferred* home plumbing await the convalescent patient at Victory Memorial. Take special note of the Crane *Newvogue* bathtub—chosen for several de luxe rooms. Although the *Newvogue* is a full size tub, it measures only 48 inches across. The built-in seat affords comfort and complete safety while foot, sponge or shower bathing. Other fixtures shown here are the Crane *Norwich* lavatory of sanitary vitreous china and the Crane *Walton* closet with efficient siphon jet action. Make selections through your Crane Branch, Crane Wholesaler, or Local Plumbing Contractor.

GANSTER & HENNIGHAUSEN, Waukegan, Ill.
ARCHITECT
HOTHAM & KOETZ, Zion, Ill.
PLUMBING CONTRACTOR
JENKINS & BOLLER, Waukegan, Ill.
GENERAL CONTRACTOR

CRANE CO.

GENERAL OFFICES 836 S MICHIGAN AVE., CHICAGO 5
VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

Conducted by Alta M. Le Belle and Jane Barton

Housekeeping Speeds Miss Brown's Recovery

MADGE H. SIDNEY
Executive Housekeeper
Evanston Hospital
Evanston, Ill.

TO FIND housekeeping on any hospital organization chart takes close scrutiny. It is usually in an insignificant lower corner and looks almost minute compared to most of the other departments. However, we who are a part of housekeeping realize its importance and know that our own departmental chart is most impressive and shows housekeeping as it really is—a tremendously large organization made up of various and sundry subdepartments.

The gist of this discussion will concern the functioning of Evanston hospital, Evanston, Ill., but with few variations it can be applied to any hospital.

LET'S FOLLOW THE PATIENT

I could make a broad statement and say that everything done by housekeeping has a part, directly or indirectly, in the care of the patient, but to be more explicit let's travel with an imaginary patient from the time of her admittance until she leaves the hospital. Even an imaginary patient must have a name, so we'll call her Miss Brown, and her ailment—not serious, though painful—an acute back strain.

Miss Brown's first contact with housekeeping is when she is greeted at the ambulance entrance by the pleasant, liveried doorman, who makes her comfortable on a cart or in a wheelchair, as the case may be, then calls an orderly.

Miss Brown is too sick to realize that the neat, uniformed elevator girl who takes her to the orthopedic floor is also part of housekeeping, nor does she notice the porter cleaning hall light fixtures or the maid busily mopping in a vacant room preparing it for a new patient. In fact, for the first few days she cares little about anything except her doctors, nurses and sedatives to relieve her of the pain and the discomfort of traction. But during this period, housekeeping contributes toward her well-being.

Perchance the window washer slips in quietly and cleans the windows or the venetian blind girl deftly cleans the blinds. Mayhap extra blankets or pillows are delivered by the assistant housekeeper for the added comfort of the patient, or a package and flowers, after having been checked in by the doorman, are delivered to the room by an elevator operator or a porter. Every hour of every day housekeeping activities are going on throughout the hospital. In West Building a porter is fumigating a load of blankets and mattresses from the contagious floor; in General Building a porter is collecting garbage from the floor kitchens, while another is exchanging a triple gatch spring bed for a new self-adjusting type. Indirectly doesn't all of this pertain to care of patients?

Next door to Miss Brown, the painters are following up the wall washer and because of the south exposure, they are applying a cool, soft shade of green which blends with colors in the attractive draperies that have been selected, while, at the same time, the upholsterer and refinisher are busy working in their shops, all with the same goal in mind—a finished room that will afford a pleasantly cool, comfortable atmosphere to any patient.

The morning of her third day in the hospital, Miss Brown wakes up feeling better. She has her breakfast, her bath, is made comfortable by the nurse, and is left to rest between clean fresh sheets until the arrival of her doctor.

Following the pattern of most women, she begins to give thought to her personal appearance. A little powder and lipstick—she'll ask the first person she sees. This happens to be a smiling maid in a pretty cherry colored uniform with white collar and cuffs. At Miss Brown's request, the maid moves the bedside table within reach and gives the patient her make-up. Not exactly housekeeping, but a service rendered to a patient, and a direct service this time. In fact, many times a housekeeping employe is found helping a patient in some small way, assuming tasks normally belonging to other departments. A call for help—housekeeping to the rescue. Hospital housekeeping is no longer in its infancy. Housekeeping is ready and willing to accept the added responsibilities necessitated by the shortage of nursing and other personnel. This is imperative for normal growth and expansion of hospital housekeeping.

THE SERVING ROOM CONTRIBUTES

Getting back to our imaginary Miss Brown, she watches while the maid performs the daily duties of cleaning and tidying the room. She begins to take an interest in her surroundings. At 11 o'clock she is taken to the newly improved physical therapy department to spend a half hour in the Hubbard tank. Here, too, are signs of housekeeping care: clean curtains enclose the tank, a clean floor, bath blankets and towels fresh from the laundry. Our Miss Brown doesn't know that all of these curtains, as well as bathing suits and even draperies, are made in the housekeeping sewing room, where four seamstresses spend all of their working hours mending and sewing, making approximately 100 different items ranging from small eye pads and baby mittens to the heavy canvas which is securely laced to the frame of the very stretcher on which she is now relaxing in the warm water of the tank.

Does a patient ever wonder about these things? Probably not, and it

Presented at the Tri-State Hospital Assembly, May 1951.

really doesn't matter as long as the patient benefits by them.

Now, mind you, all during Miss Brown's stay in the hospital she is getting the best medical and nursing care, to say nothing of the well balanced, tasty meals served by the dietary department. But we must concentrate on housekeeping and its care of the patient.

On the way back to her room, Miss Brown passes the housekeeping office on the ground floor, conveniently close to the ambulance entrance and elevators, and directly above the basement storerooms. It is a large, light office with plenty of room to accommodate half of the housekeeping personnel at one time for training programs and meetings. In fact, a semimonthly maid's meeting is in session now, and the assistant housekeeper is trying something new. A panel made up of four maids is answering questions and problems presented by some of the 30 or 40 maids present. Each maid has an opportunity to serve on the panel and all are urged to bring their own problems up for discussion. (This is one time the housekeeper takes a back seat.)

THE PATIENT IS ALWAYS RIGHT

How does this pertain to patient care? Let me give you one question and answer as an example: A new employe said, "My problem is an elderly patient—an old crank—fusses at me because I don't put his wastebasket back in exactly the same place each day. He's getting on my nerves. What difference does it make where I put the basket? How can I stop his fussing at me?" The chairman of the panel, who has worked in the same section of the hospital for nearly 25 years, gave her this answer: "Remember, the patient is always right as far as we are concerned, and remember too, we don't know just how sick the patient is, so you just put that basket wherever he says he wants it and smile when you do it. Don't *ever* upset a patient."

This solved the problem, and wisely too, because the patient proved to have a heart ailment which could have been seriously affected by any slight emotional upset. Sometimes, instead of panels, educational movies are shown, like "Dusting," loaned by Illinois Bell Telephone Company, or "You're the Doctor," or the new atomic movie. Often excerpts are read from good books on housekeeping. These meetings—shouldn't they come under the heading of patient care?

Miss Brown must be back in her room by now. Let's hurry and catch up with her. She's sitting up in bed enjoying the pleasant view through the shiny window. Does she wonder when and how it was cleaned? No, but she's enjoying it along with the attractive furnishings in her room. Even though you were to tell her that the executive housekeeper spent a great deal of time and thought selecting and buying these things, she wouldn't care particularly. All she wants is to enjoy the comfort of it.

Housekeeping employes should be seen and not heard. They should get work done unnoticed. Fresh bars of soap, paper towels, toilet tissue in the bathroom—did they appear by magic? Well, yes, by the magic of housekeeping.

Comes the day when our patient walks down the hall to the cast room. "Now, Miss Brown" (if you follow an imaginary patient long enough you're bound to talk to her), "Who cleans the plaster off the floor after the medical personnel has finished molding a cast for you? That's right. The same ones who mop the floor in operating room between operations and the floors in the delivery rooms between cases—housekeeping!"

Miss Brown, now back in her room, is tired and thirsty. A glass of ice water beside the bed—so refreshing. The ice? A housekeeping employe spends about 3000 work hours a year just delivering ice to nursing floors and kitchens for the patients. A radio for Miss Brown? Call housekeeping, that's all. You ask why no one is ever seen mopping the halls, though they always appear clean? All public spaces and halls are mopped at night while the patients sleep. This has been going on for three years and we have never had a complaint from a patient. The five men who work quietly up and down the halls, stairs and offices from 11 at night until 7 in the morning serve another purpose. They belong to our fire brigade and stand ready for any emergency. A patient should sleep well knowing that hospital personnel is trained and ready to protect day and night.

It's nearing the date of departure for our imaginary patient, but before she leaves, let's take stock of some of the many services rendered by housekeeping that indirectly play a part in the care of patients.

COVERS A WIDE RANGE

The primary function, keeping the hospital clean, giving the patient confidence and a better chance of recovery, means many things to the executive and her assistants: bacterial surveys; study of safety methods; attendance at safety and fire safety committee meetings; taking inventories; budgeting; buying; preparing pay rolls; assisting the administrator and other department heads in planning for new construction which necessitates a knowledge of blueprints; studying and applying economy in personnel, equipment, supplies, technics, procedures; a thorough understanding of linen control; interior decorating; constant supervision and inspection; organizing and scheduling of work; exchanging and contributing ideas at housekeepers' meetings, institutes and assemblies, and last but not least, keeping the nurses', interns', and employes' homes as attractive and comfortable as possible, always remembering that happy personnel means better care for the patient.

So we say farewell to Miss Brown. We hope she has enjoyed and benefited by the excellent care of our professional personnel and *because* she hasn't realized the part housekeeping has contributed to her care, we pat ourselves on the back for a job well done. The magic of good housekeeping—no praise, no recognition from the patient, but certainly a friendly appreciation from other departments and personnel for *our* cooperation and aid in *their* care of the patient.

Labor Gets Rough in Minneapolis Strike

(*Continued From Page* 53)

Most of the hospitals, it was learned, are on an 80 hour two-week schedule with two consecutive days off a week and with Sunday and Monday off every other week.

So much for the union. From the hospitals' point of view the real issue at stake was the union shop. Boards of the 10 hospitals, at the start of negotiations, voted their "unalterable opposition" to a union shop and sent notice of their stand to the hospital council. Until this issue was dropped, hospital administrators refused to discuss any of the other issues involved. This accounts for the hospital heads' extraordinary devotion to the weather as a conversation piece at conciliation sessions.

Regarding the five-day week, Russell Nye, administrator of Northwestern Hospital, told The MODERN HOSPITAL: "If the public and labor wants a five-day hospital week, it is theirs if they will pick up the tab. It will cost our hospital 92 cents more per patient per day."

When, on June 26, the workers walked out a number of the hospitals started hiring permanent replacements. Some of the "vacationers" speedily returned, but to the others pay checks, stating that they were final, were sent out by registered mail.

Volunteers rushed in where some potential replacements feared to tread. The women's boards and auxiliaries, polishing up World War II skills, took over messenger service, tray carrying, bed making and the like. If they snatched a few minutes off for news photographers, that, plus virtue, was their sole reward. The total square footage of floor space scrubbed by debutantes had best not be computed, but the stories the various groups of volunteers carried back into the community contributed measurably to public sympathy for the hospitals.

High school youngsters, hastily hired, took over many laundry and dishwashing jobs. The work was hard, and the rooms hot and heady, but they were in the company of their peers and that's "george" with the blue jean set. Their reward would come on pay day. Came, too, merry little pauses in the day's occupation which were utilized for thumbing noses at the pickets outside and shouting TV-type insults, fortunately never heard above the hum of the machines they were manning with increasing eptitude.

A closely held strike secret was the hospitals' trick of smuggling in limited supplies of fresh meat and milk. Mostly, however, the menus were built around canned goods, supplies of which dwindled away from quick consumption. In several hospitals, the dietitians were confronted with the unwelcome task of cooking from their own recipes. At one institution a screeching ambulance swept past the awed picket line bearing a paralyzed man, whose apparently anxious companion was his wife—a substitute cook. Because of waning food and laundry supplies a few hospitals closed their doors to all except emergency admissions.

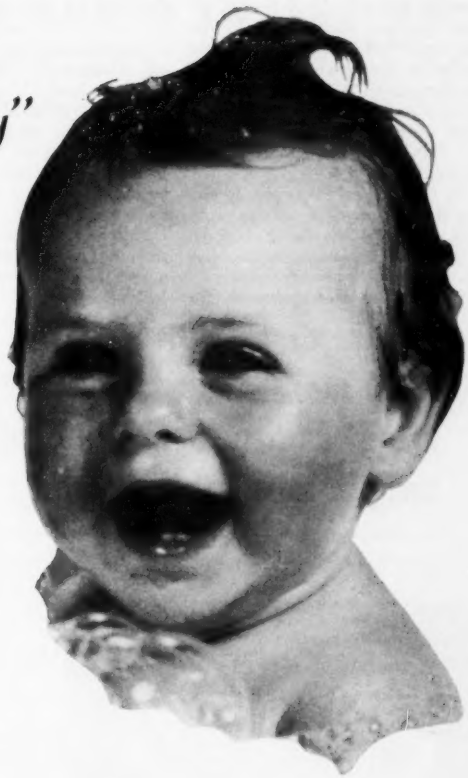
The temper of the town was not hard to gauge. The "capitalistic press" was solidly behind the hospitals, and professional and business men called it a "damned outrage" and a "stinky business." Members of other unions seemed to take the strike fairly lightly. Taxi drivers regarded it as a minor affair—not much discussed.

One driver showed by his remarks how stupendous is the public relations task of hospital administrators and directorates everywhere. "The cost of living is high," he explained, "and the hospitals are charging stiff prices for their rooms. They must be making money and certainly could afford to pay a decent wage." Perhaps some of the building service employes themselves are as ill informed.

The lesser Twin City, population-wise, feels a little superior to its Mill-on-the-Mississippi neighbor. Its hospitals settled with Local No. 113 to the professed satisfaction of both parties. St. Paul hospitals gave a little and gained a little and are congratulating themselves on their tact and finesse.

They granted the union the 5 cents an hour raise requested and they made it retroactive to March 1. They told the union that the closed shop was "absolutely out" and will always be out of their reckoning. They conceded to the union a pledge to turn

We've coddled this famous "Baby" for 72 years.



No mother's "Pride and Joy" ever received more loving care than Ivory Soap. For 72 years Ivory's purity and mildness have been our constant concern.

That fact is important to you in the hospital field. For in Ivory you have a soap especially fitted to provide the thorough, gentle cleansing so essential to patient care.

Today's Ivory is a finer Ivory than ever before . . . handsomer than ever . . . easier to handle . . . more generous lathering qualities in water soft or hard. Your purchase of Ivory offers you far-better-than-average value for your soap dollars.

For hospital use Ivory Soap is available in the popular* 3-ounce size as well as in smaller sizes, wrapped or unwrapped.

*Packed weight

99 44/100% Pure ..... It Floats

Procter & Gamble CINCINNATI, OHIO

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!

over the names and addresses of all new employes, after having advised the newcomers that they may join the union if they wish but that it is not compulsory. This is a small enough concession, St. Paul administrators believe, inasmuch as the shop steward has all these names within a few days anyway.

St. Paul hospitals were already giving their employes a five-day week with two consecutive work days off. Under the new contract, the two days off do not have to be consecutive.

Said a prominent spokesman for the three St. Paul institutions: "St. Paul always has been a little more lenient with labor than has Minneapolis. Consequently labor relations are smoother here. We have not had many strikes in industry, despite rather poor leadership. Of course, they could begin, but I do not think so."

Having heard consistently damaging testimony regarding Local No. 113's strike tactics at the 10 hospitals, the court on that Saturday issued a restraining order against picketing and against union encouragement of the strike, and set July 12 as a show-cause date why a similar temporary injunction should not be granted to continue in force until final judgment was made.

The sheriff served his papers, and the sweaty pickets began to desert their beats around 3 p.m. of July 7. With the sun and humidity teamed against them, their chief aim now was the chance to soak their burning feet.

A number of strikers were eager to return to their posts the next day, but the volunteers had already been scheduled for Sunday. Monday morning found some strikers back on the job at Asbury and St. Barnabas hospitals; the other eight hospitals held firm in their resolve not to receive any of them unless forced to do so by a strike settlement agreement.

The Sisters at St. Mary's had to call out the police when 18 strikers threatened to enter the building by force to resume work. The Sisters stood pat, and with the Bishop's blessing.

A hot blast from Goonville whipped up the troubled air. An anonymous voice on Administrator Russell Nye's telephone said: "Get yourself out of town by tomorrow night if you don't want to be riddled with bullets." The call could not be traced. Mr. Nye stuck by his desk.

The day school was out Mr. Nye had rushed his three children out of Minneapolis, and his wife followed on the day the strike became official. These precautions were induced by a threat against the Nye children made last Thanksgiving when a strike was narrowly averted.

A number of hospital folk in Minneapolis believe that a Communist element may be involved in the controversy. Certainly the Catholic Sisters have been roughly treated throughout the current trouble. The singling out of Nye and his family is thought possibly to be a manifestation of class hatred, since the 50 women members of the Northwestern Hospital board and the 65 girl members of the junior board belong to old families, many of them with considerable wealth.

District Judge La Belle on July 13 issued two orders. One overruled the union's contention that the law forbidding strikes at charitable hospitals is unconstitutional. The other ruling, in effect, requires the hospitals to take back on their pay rolls workers who, the union claimed, had been "illegally locked out." This involved some 300 workers.

GOOD CHEFS INSIST ON GOOD CUTLERY

Chef Paul Brunet of the Palmer House, Chicago, is an enthusiastic user of Wear-Ever Professional Cutlery.

Examine Wear-Ever Professional and you'll agree it is cutlery at its finest. Blades are made of high carbon, chrome vanadium steel for hardness, fine texture and toughness. On pieces where stainless steel is most adaptable, a special high carbon alloy is used. The steel is drawn to just the right hardness for professional use where blades are frequently honed. Full tang construction, compression type rivets, perfect balance. Smooth, hand-fitting handles of Ebonwood. Made in the world's most modern cutlery plant. Ask your supply house representative to show it to you or mail the coupon below for catalog and details.

Also—Wear-Ever Professional Cutlery for the Butcher Shop and Bake Shop . . . a complete line for every kitchen need.

SEND FOR CATALOG

The Aluminum Cooking Utensil Company
708 Wear-Ever Bldg., New Kensington, Pa.

Send me your *new* catalog and full details regarding your line of Wear-Ever Professional Cutlery.

NAME .....

POSITION .....

Fill in, clip to your business letterhead and mail today

MAIL TODAY

LEARN WHAT "COLOR-ENGINEERED"

facing tile

and "The Scientific Approach to Color Specification"

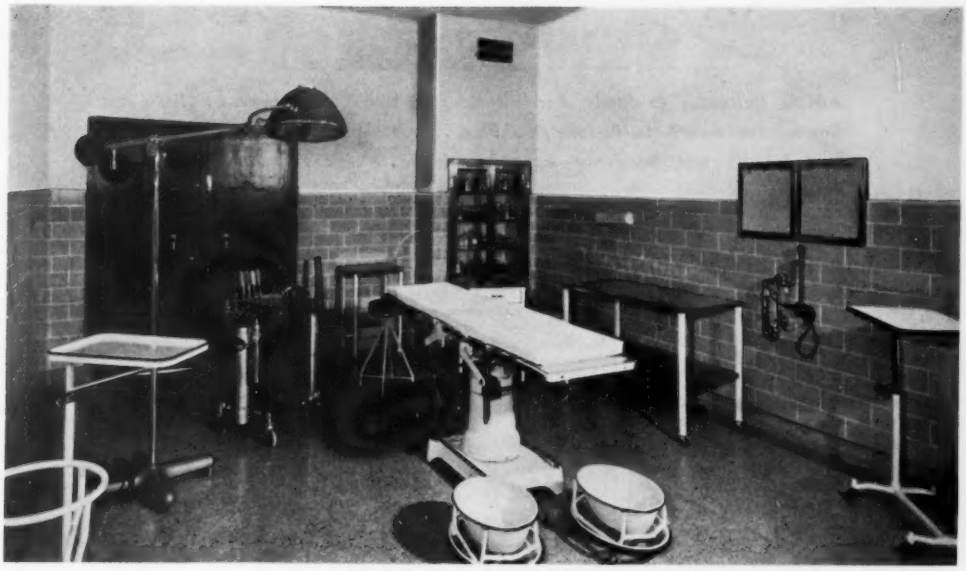
GET YOUR FREE COPY OF THIS BOOKLET— TELLS YOU HOW TO SELECT COLOR FOR HOSPITAL INTERIORS

"The Scientific Approach to Color Specification" was developed by noted color authority, Faber Birren. It tells what are the *right* colors for surgeries, patients' rooms, laboratories, cafeterias and nurseries. Learn how these Facing Tile colors will:

- increase efficiency
- aid lighting
- save eyesight
- improve morale
- cut costs
- aid convalescence

Write Dept. MH-8

FACING TILE INSTITUTE
1520 18th St., N. W., Wash, 6, D. C.



...can mean to HOSPITAL INTERIORS

Are you selecting color for hospital interiors with a scientific approach?

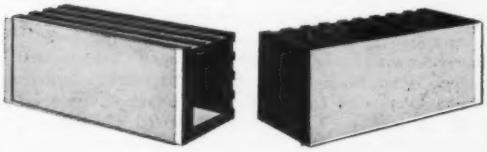
Color authorities say this is extremely important because the *right* color means better lighting, greater efficiency, higher morale.

You can select the *right* colors on a scientific basis with "color-engineered" Facing Tile. These colors have been scientifically selected and developed to help hospital interiors accomplish their purpose.

Now, any hospital interior can have all the advantages of functional color as well as all the outstanding building advantages of structural clay Facing Tile . . . resistance to wear and tear, durability, low-cost construction and maintenance.

"Color-engineered" Facing Tile builds a permanent wall and a permanent, functional finish in one operation.

Send NOW for your copy of "The Scientific Approach to Color Specification." It tells you what the *right* colors are . . . what the *right* colors will do. It is yours upon request.



FACING TILE INSTITUTE

1520 18th Street, N. W., Washington 6, D. C.

NEWS DIGEST

A.H.A. Delegates to Study Accreditation, Revision of By-Laws . . . Blue Cross Commission Award to Philadelphia Plan . . . Rochester Councils Consolidated . . . Schools List Residency Appointments . . . Maine Hospital Group Meets

Philadelphia Service Plan Given Award at Blue Cross-Blue Shield Conference

CHICAGO.—A unique sales promotion talk by assistant director Lawrence C. Wells featured the annual Blue Cross-Blue Shield Enrollment and Public Relations Conference sponsored by the Blue Cross and Blue Shield Commissions here last month.

In an elaborate stage setting simulating an old-fashioned variety store (see cut), Mr. Wells talked about the application in Blue Cross enrollment programs and other business relationships of the simple principles of human relations emphasized in the proverbs that were popular a generation or more ago.

Associated Hospital Service of Philadelphia was named winner of the commission's annual award for the best over-all public relations program carried on during the year. The jury making the award remarked particularly about the thoroughness of the Philadelphia public relation program, which took advantage of every newsworthy event to promote Blue Cross and Blue Shield interests, it was explained.

Additional public relation awards went to Associated Hospital Service of New York for a community enrollment project, Colorado Hospital Service for an individual enrollment campaign, Associated Hospital Service of Arizona for its nongroup campaign, and New Mexico Blue Cross for a community relations program.

The 225 enrollment and public relations representatives of Blue Cross and Blue Shield plans attending the conference also heard a number of talks on various aspects of sales, sales training and sales promotion by business executives outside the Blue Cross field. In an address on "The Art of Selling" J. A. Kiss, Chicago sales consultant, told the conference that "all selling is done on the basis of a human relationship, a form of building mutual understanding —a selling of an idea rather than an article." The salesman must radiate confidence in order to sell successfully, Mr. Kiss declared, because the emotional needs of the prospect or customer must be fulfilled if he is to remain a satisfied purchaser.

Mr. Wells addresses the Blue Cross conference from his old-fashioned variety store.

Other speakers at the conference discussed selection and supervision of enrollment representatives; enrollment management problems; sales training and bulletins, sales promotion and other aids, and integration of enrollment and public relations activities.

Red Cross and Polio Groups Extend Joint Agreement

WASHINGTON, D.C.—The American Red Cross and National Foundation for Infantile Paralysis last month announced continuation of the joint agreement under which the Red Cross recruits nurses to meet emergency needs during outbreaks of poliomyelitis and their salaries, transportation and maintenance expenses are paid by the foundation. In a statement released at Red Cross headquarters here last month, it was recommended that local "polio nursing committees" be organized by hospital groups to coordinate matters pertaining to nurse recruitment. "Emphasis is directed toward the utilization of local nurse resources, and the training of hospital nursing staffs to meet community needs," the statement said.

Accreditation Commission To Be Considered by A.H.A. House of Delegates

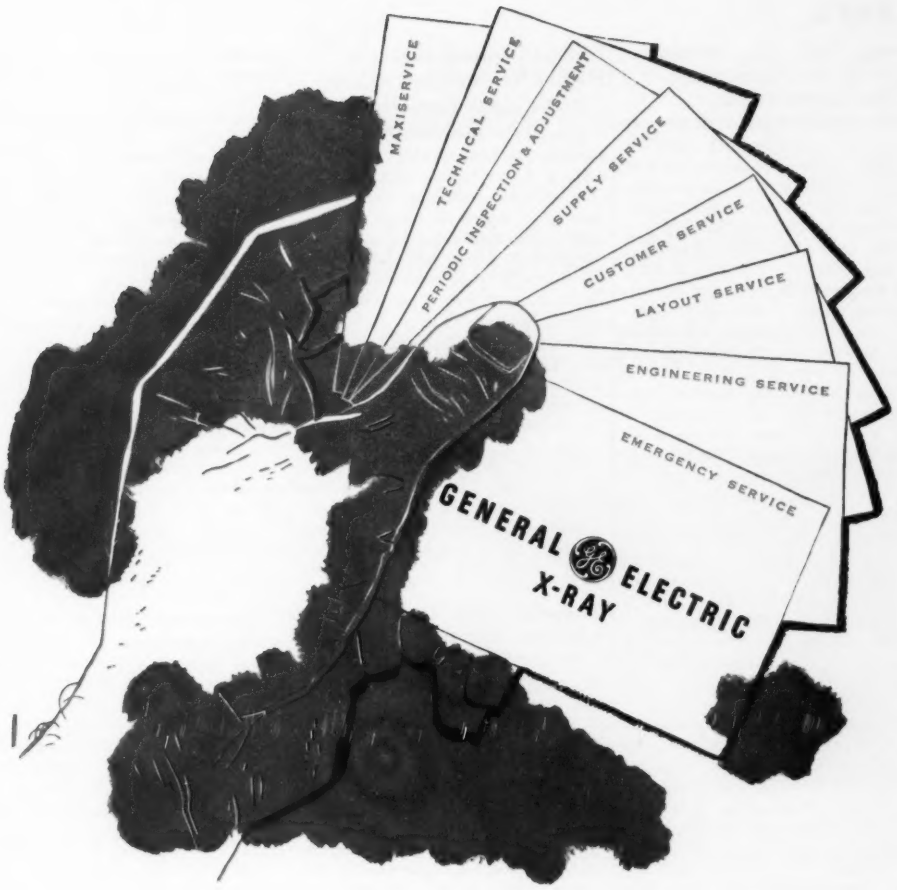
CHICAGO.—Consideration of the proposed joint commission for hospital accreditation will be the major item of business for the house of delegates of the American Hospital Association at the annual convention in St. Louis September 17 to 20. The proposed joint commission has been approved by the American College of Surgeons, American College of Physicians, and the American Medical Association and awaits action by American Hospital Association delegates before the program can be undertaken.

CONSIDER BY-LAWS REVISIONS

Delegates will also consider a proposed revision of the association's by-laws, it was announced at A.H.A. headquarters here last month. Described as a "major revision of the by-laws," the proposal represents a two-year study made by the committee on association structure, it was explained. "The revision recommends many changes which will permit more effective service by the association," a headquarters announcement said.

General sessions of the convention will consider such subjects as hospitals and the practice of medicine, trends in Blue Cross and other "third party" programs, the quality of hospital service, standardization and efficiency in operation, an announcement stated. In section meetings, special attention will be devoted to food service, purchasing, personnel, nursing and hospital auxiliary activities.

In a concurrent meeting, the American Association of Nurse Anesthetists will study the social and legal aspects of anesthesia service, an announcement from association headquarters here stated. The program will feature a panel discussion of anesthesia service by an attorney, a hospital administrator, anesthesiologist, a director of nursing and a surgeon, it was explained.



ONE CALL FOR ALL

...when you call your GE x-ray representative

or X-ray Department, General Electric Company, Milwaukee 14, Wis.

You can put your confidence in—

GENERAL ELECTRIC

NEWS...

Charges N.Y. City Hospitals With Major Violations of Fire Safety Rules

NEW YORK.—Voluntary hospitals were given a comparatively clean bill of health but municipal hospitals were charged with numerous major violations in a fire safety survey completed here last month by Deputy Chief David J. Kidney, head of the city's division of fire prevention.

In a report made public by Fire Commissioner George P. Monaghan, only a few voluntary hospitals were charged with violations and these were minor in character, it was indicated. At least 25 city hospital buildings, however, were found unsafe and, in some cases, "in dire need" of major fire protection changes or installations. Estimates of the cost of needed improvements range to more than $1,000,000, according to city hospital department officials.

Following release of the fire prevention report, city hospital commissioner Marcus D. Kogel agreed that necessary minor corrections should be made at once but protested that installation of modern fire prevention equipment in some of the older hospital buildings covered in the survey would be "pouring money down a rat hole."

Citing a 125 year old hospital building on Welfare Island which the fire safety survey revealed needed a sprinkler installation, Dr. Kogel contended the recommended installation would cost hundreds of thousands of dollars—not only for the needed equipment but also to strengthen the structure itself and install new drainage facilities. And, he added, "as soon as the work was finished the building would be torn down and the money wasted."

Dr. Kogel acknowledged the existence of fire hazards in many city hospital buildings but said the department was doing "everything possible" to guard against fire. "We've got to be realistic about this thing," he said. "We want to evacuate all the worst firetraps just as soon as possible—just as soon as we can get sufficient new buildings. Right now, the case loads are so great we haven't been able to evacuate a single building. We have waiting lists—people who should be in hospitals. Only we don't have room for them.

"The fire department, not long ago, slapped us with a violation because we had patients in a hallway. What were we going to do? That's the only place we had to put them."

Illinois Committee Urges Higher Ceiling Payment to "Special Inclusive" Hospitals

CHICAGO.—Establishment of a new hospital classification which would receive a higher ceiling payment from state agencies purchasing hospital care than any of the existing three classifications was recommended last month by the technical advisory committee for the purchase of hospital care of the Illinois Hospital Association. Under the recommended new classification, it was explained in a bulletin released by the Chicago Hospital Council, hospitals rated as "special inclusive" would receive their reimbursable costs up to a ceiling of $20.19 per patient day for care of indigents.

The "special inclusive" group would consist of hospitals having the facilities and services described as "inclusive" under the present classification system and having in addition organized outpatient departments, organized physical therapy departments, organized medical social service departments, and resident and intern training program supervised by a medical school, it was explained.

The present classifications, which are based on the completeness of facilities and services offered to patients, are: inclusive, to receive cost up to a ceiling of $18.39 per patient day; intermediate, with a ceiling at $13.85, and basic, with a ceiling of $12.68.

"The technical advisory committee has recommended that all governmental agencies pay hospitals for care rendered public assistance cases on the basis of the hospital's full per diem costs within the ceilings for each classification," the council bulletin states. "Committees of the Illinois Hospital Association and the council have been earnestly working for adequate payment from the public agencies. It is hoped that positive action will be taken by these agencies in the near future."

Organize New Rochester Regional Hospital Council

ROCHESTER, N.Y.—The consolidation of two organizations, the Council of Rochester Regional Hospitals and the Rochester Hospital Council, into the Rochester Regional Hospital Council, Inc., was completed June 25 at a meeting here at the Rochester Academy of Medicine.

The new organization, representing 29 hospitals in Rochester and the 11 county region, was consolidated primarily in the interest of efficiency and economy and was chartered by the state for the purpose of "improving hospital and health facilities and services."

Officers of the council include: president, George J. Hucker, chairman of the board of trustees of Geneva General Hospital, Geneva; vice president, Frank H. Hamlin, F. F. Thompson Memorial Hospital, Canandaigua; secretary, L. Dudley Field, North Park and Park Avenue hospitals, Rochester, and treasurer, Lawrence J. Bradley, Genesee Hospital, Rochester.

Members of the council's executive committee are: George D. MacBeth, Corning Hospital, Corning; Harlan F. Calkins, Highland Hospital, Rochester; Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester; Hathaway Turner, Shepard Relief Hospital, Montour Falls, and Thomas R. White, Rochester General Hospital.

The executive committee, in its first meeting, appointed Dr. Albert D. Kaiser, Rochester city health officer, as medical associate and named Charles M. Royle as executive director. Mr. Royle previously served as administrative officer of both the Rochester and the earlier regional council.

A saving of about $30,000, or approximately 25 per cent, from the combined budgets of the two separate councils was represented in the budget of $98,072.15 for the fiscal period ending March 31, 1952, which was adopted by the board.

Revenue is received principally from the Commonwealth Fund, which has contributed $49,166; the Rochester Community Chest, which gave $27,969, and the Rochester Hospital Service Corporation, which has allocated $15,000. Assessments on member hospitals make up most of the remainder of the income. The Commonwealth Fund has indicated that it will continue support, in decreasing amounts, for the next two or three years.

Mr. Hucker called upon other members of the board to make the council "more than just a service organization." He said, "We need to get all the trustees of all the hospitals in the region to thinking about hospital matters, and about broadening the scope of what hospitals can do throughout the entire area."

Now...an authoritative report on adhesive and skin irritation

Freedom from skin irritation is, of course, one of the basic qualities desired of any adhesive.

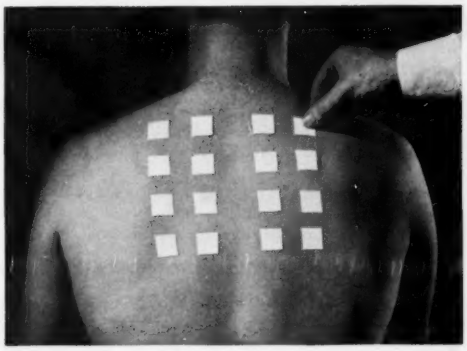
For many years, the makers of *Curity* Adhesive have pioneered in minimizing the skin irritation factor in the use of this product. And a substantial number of clinical studies have been made on the matter, by independent sources.

In 1937, for example, we pioneered the introduction of new non-irritating ingredients into our adhesive mass, which reduced skin irritation to a minimum. We then commissioned the dermatology department of a well-known university to make a thorough study of our own and other leading brands of adhesive, with reference to skin irritation. The findings then were that *Curity* Adhesive caused significantly less skin irritation than other brands tested.

Since that time we have maintained a continuing program of clinical research on this subject. In all cases, the findings have corroborated that reported above.

The most recent of these studies was conducted by a consulting biochemist of very substantial reputation, who was commissioned by Bauer & Black to investigate the incidence and degree of skin irritation and allergy caused by adhesive. This clinical study was made with *Curity* Adhesive and with two other leading brands. In making the analysis, a substantial sample was used, and a very careful system of checks and controls was employed to assure a thoroughly unbiased, complete and objective report.

A summary of the findings has now been compiled. It verifies a fact borne out by earlier studies: viz., that *Curity* Adhesive is measurably less irritating than the other brands tested.



Copies of the findings, in digest form, are available to any member of the medical profession on request.

Curity may be depended on for adhesiveness, ease of application and removal, uniformity and minimal skin irritation. These are the reasons why *Curity* is a wise choice for all hospital and office use.

Curity
REG. U.S. PAT. OFF.

ADHESIVE

BAUER & BLACK
Division of The Kendall Company

NEWS...

A.H.A. Sponsors Meeting With "Third Party" Agencies To Discuss Hospital Costs

CHICAGO. — Representatives of hospitals, Blue Cross plans, community chests, government health and welfare departments, labor unions and other "third party" purchasers of hospital care met here last month to discuss hospital payment programs and develop principles which should govern the relationship between hospitals and contract purchasers. The conference was sponsored by the American Hospital Association. Dr. A. W. Snoke, director of the Grace-New Haven Community Hospital, was chairman.

Following several sessions during which every aspect of the contract payment relationship was thoroughly discussed from the standpoint of the hospital, the paying agency and the beneficiaries, the conference evolved a statement of principles which was to be circulated among interested organizations and groups for comment and suggestions.

Principles approved by the conference included a concept of full cost reimbursement which recognized responsibility for the provision of adequate facilities and comprehensive service—"in the best tradition of present-day American hospital practice." Other factors properly included in consideration of contract reimbursement, according to the principles developed in the conference, are continued improvement of administrative and professional practice to achieve maximum essential service to patients at the lowest possible cost to the purchaser consistent with high standards of care; development of criteria by which hospitals can evaluate the quality, scope and efficiency of their own services; responsibility for making available to group purchasers "fiscal and administrative statistics and data necessary for a continuing agreement on amount of payment and services provided," and uniform and accurate accounting looking toward provision of operating cost statements prepared in accordance with agreed cost formulas.

The conference disapproved "arbitrary ceilings" in payment contracts and indicated that per diem ceilings should never be used by contracting agencies to avoid paying full cost. However, it was agreed, "It is recognized that nonprofit agencies purchasing hospital care on a 'full cost' basis may, in some instances, be required by necessity to establish per diem ceiling rates that will be paid when there is a wide variation in per diem operating costs between hospitals in a given area offering essentially the same services; provided, however, that when such limitations must be established they will be negotiated with hospitals concerned, and make provision for expanding standards and scope of services as well as for upward movements in cost of operation."

Shriners' Hospital Board Votes to Increase Dues

NEW YORK.—The hospital board of the Imperial Council of the Ancient Arabic Order of Nobles of the Mystic Shrine has voted to increase the annual assessments of members from $2 to $5 because more funds are needed for the hospitals the organization maintains, according to Galloway Calhoun, chairman. The proposed action was presented to members at the 77th Shriners' convention here.

Mr. Calhoun said the organization supports 17 hospitals at an annual cost of $3,000,000 each. The newest, a $2,300,000 institution for orthopedic children up to 14, which is located in Los Angeles, was also discussed at the hospital board's meeting. Plans to renovate the hospital at Lexington, Ky., were also discussed.

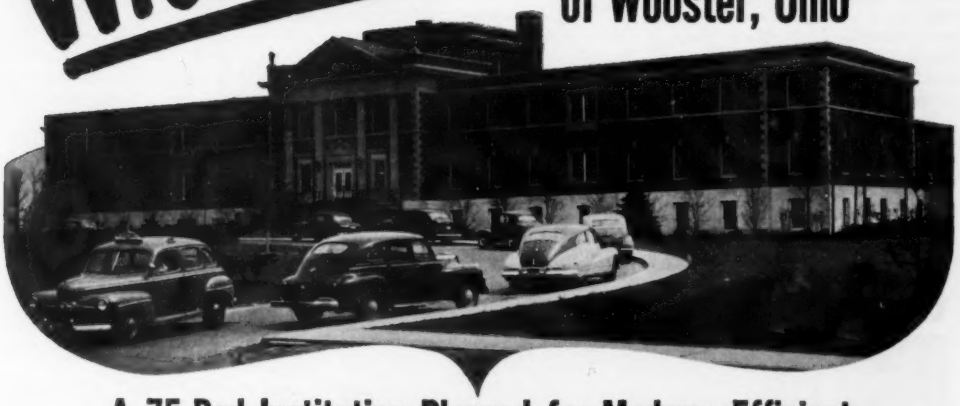
Brooklyn Council Elects

NEW YORK. — The following officers were elected at the meeting of the Hospital Council of Brooklyn, Long Island and Staten Island held in June at Mercy Hospital, Rockville Centre, L.I.:

President, Arthur Feigenbaum, Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn; vice president, Rev. Clarence A. Morrill, Methodist Hospital, Brooklyn, and secretary, Sister Ursula Marie, Mary Immaculate Hospital, Jamaica.

Members of the executive committee are: Mr. Feigenbaum; the Reverend Morrill; Sister Ursula Marie; H. F. Rudiger, Southside Hospital; Dr. I. Magelaner, Kings County Hospital; Sister Mary Anna, Mercy Hospital, and Louis Schenkweiler, Wyckoff Heights Hospital.

Witness the Wooster Community Hospital of Wooster, Ohio



A 75-Bed Institution Planned for Modern, Efficient Linen Service with HOFFMAN Laundry Equipment

Three sizes of Hoffman "Silver Crest" washers provide flexibility for any combination of soiled linens. Extractors are 40-inch "Open Top" and 17-inch "Vortec" (not shown).

Fast, high-quality production of flatwork is accomplished on this 4-roll, 110-inch Hoffman Ironer, complete with canopy . . . faster drying with "Greyhound" tumbler (not shown).

Recent opening of this private, non-profit Wooster hospital emphasizes the *completeness* of Hoffman laundry equipment service. Even the smallest laundry is big in importance. That's why Hoffman is prepared to furnish the right size and type of machinery for laundries with smaller linen loads. And offers the same engineering survey and planning assistance provided to larger institutions. Scores of medium- and small-size hospitals have gained top linen output, lowest operating cost and maximum convenience by calling on Hoffman's specialized engineering counsel. Request it for your laundry planning.

For New or Modernized Laundries
FREE Engineering Survey

Analyzes your laundry costs; surveys your linen requirements and suggests control schedules; furnishes new layout plans; recommends equipment to help you save floor space, time, labor, fuel, supplies and linen.

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

NEWS...

Sister Annunciata To Head Maine Hospital Association

BELGRADE LAKES, ME.—Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association, was the guest of honor at the annual meeting of the Maine Hospital Association held at the Belgrade Hotel here June 22 and 23. Registration was estimated at about 175.

The first session was a suggested procedure for admission on patients covered by group insurance plans which was given by L. A. Orsini, manager, group division, Bureau of Accident and Health Underwriters, New York. Following this, Mary Field, director of volunteers, Salem Hospital, Salem, Mass., spoke on the "Volunteer Worker in the Hospital." "Nursing, A Part of the Total Hospital Picture" was the subject of an address by Ellen Creamer, associate professor, department of nursing, Syracuse University.

The afternoon session on the first day was opened by the president's address by Pearl R. Fisher, president of the Maine Hospital Association. This was followed by a symposium on public relations with Dr. Charles Branch, Central Maine General Hospital, Lewiston, presiding.

Speaker at the annual banquet was Dr. Dean Clark, director of Massachusetts General Hospital, Boston, who discussed some of the current problems relating to specialist services in the hospital. He was followed by Dr. MacEachern who brought the greetings of the American Hospital Association.

The morning program on the second day was on civil defense. It was a panel discussion entitled "The Place of the Hospital in a Program of Civil Defense." Dr. Frederick T. Hill, medical director, Thayer Hospital, Waterville, acted as moderator. Various hypothetical problems representing typical disaster situations were discussed.

The afternoon session was a symposium on "How to Control Costs" with Frank Bosquet, administrator, Augusta General Hospital, as chairman.

Running concurrently with these general sessions were meetings of the Maine Medical Record Librarians and the Women's State Hospital Auxiliary.

Association officers elected for the coming year are: president, Sister M. Annunciata J., R.N., Mercy Hospital, Portland; vice president, Dana S. Thompson, assistant director, Central Maine General Hospital, Lewiston; secretary, Lawrence M. MacDougall, Eastern Maine General Hospital, Bangor, and treasurer, Frank Bosquet.

The executive committee, in addition to the officers, include Mrs. Mary Morris, trustee, Miles Memorial Hospital, Damariscotta, and Pearl R. Fisher, R.N., Thayer Hospital, Waterville.

The hospital association endorsed a petition in support of the Bolton Bill and urged the continued support toward the passage of a hospital lien bill in the next legislature. The association also passed a resolution requesting the governor of Maine to appoint a duly qualified commission to study the situation relative to the serious shortage of nurses and other professional personnel in Maine hospitals.

Hospital Receives Bequest

TORRINGTON, CONN. — A bequest from the late Mrs. Clara M. Swayze of $1,200,000 to the Charlotte Hungerford Hospital here was announced last month.

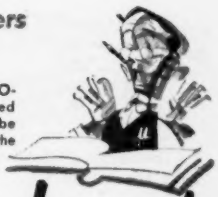
GARLAND

SPECTRO-HEAT HOT TOP

Makes Everybody Happy!

Makes Cost-Keepers Happy!

Spectro-Heat Hot Top is ECONOMICAL! Individually controlled burners! Gas consumption may be cut in half without restricting the cooking area!



Makes Chefs Happy!

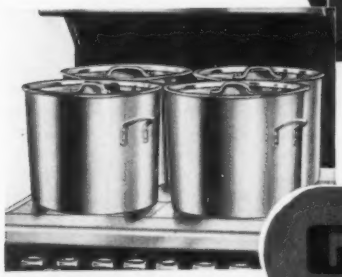
Spectro-Heat Hot Top is FLEXIBLE! Reduces shifting of heavy stock pots! Front-firing makes entire top workable.

Makes Food Lovers Happy!

Spectro-Heat Hot Top in the hands of a good chef does an EXCEPTIONAL COOKING JOB. Restaurants, hospitals, schools, institutions of all kinds praise it.

Only GARLAND the leader has SPECTRO-HEAT

Seven front-fired burners deliver heat to the Garland cooking top with *graduated* intensity. No other hot top gives you front-firing on so many individually controlled burners! No other hot top can deliver the advantages of *Spectro-heat!* Be sure to see GARLAND when you buy. It's first in *quality*, first in *value*, first in *sales*. All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.



BIG CAPACITY—Spectro-Heat top is 34-in. wide. Holds four large size stock pots!

Makes Servers Happy!

Spectro-Heat Hot Top is FAST! Seven powerful burners deliver intense heat instantly! No back-up of orders! No disgruntled customers!

GARLAND

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers
Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges

PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

NEWS...

Surgeons' Responsibility to Society Stressed by Speaker at A.M.A.

ATLANTIC CITY, N.J.—In an address on "The Responsibility of the Surgeon to Modern Society," Dr. I. S. Ravdin, chief surgeon of the University of Pennsylvania School of Medicine and Hospitals in Philadelphia, called upon American surgeons to clean house of certain practices by a small segment of surgical practitioners.

The address was made at the annual meeting of the American Medical Association.

Professor Ravdin said that this segment "threatens our great heritage." He urged the medical profession to unite for a solution to the following problems: (1) overcharging of patients for surgical services rendered; (2) elimination of needless operations when the symptoms of these patients are really psychosomatic; (3) splitting of fees between the internist or general practitioner and surgeon; (4) "ghost surgery," in which the general practitioner employs a surgeon to do operations in cases where the surgeon has had no part in the decision of whether the operation is necessary and also where the patient is led to believe that his own physician has performed the surgery; (5) calling consultants in cases where it is unnecessary and at times forcing the use of a particular group of consultants, and (6) making sure that surgery is performed only by those who have been properly trained to do it.

Hospital Officials Attend Credit Conference

CHICAGO. — A number of hospital business managers and credit officers attended special meetings for hospital and professional people in connection with the 37th annual International Consumer Credit Conference sponsored by the National Retail Credit Association here last month. R. H. Thomas of the Grace Hospital, Richmond, Va., was chairman of the hospital and professional section. He was assisted by Mrs. C. L. Hollis, Dr. Hal C. Miller and Dr. T. R. Staton of Atlanta, Ga. Subjects discussed by the group included public relations and problems arising in handling patients and their families, interest charges on installment payments, courtesy discounts, importance of advance credit applications, and the outlook for hospital and clinic collections during coming months.

Sign, coping and horizontal decorative fluting all are ENDURO *Stainless Steel, fabricated by a local sheet metal contractor. Architect is Joseph Baker, Columbus, Ohio.*

Ready for a *Lifetime* of weather

Detail of entrance way to office wing. Horizontal fluting, door and window frames are stainless steel.

RECENTLY-COMPLETED additions to Mercy Hospital in Columbus, Ohio, are tastefully modern. Large brick and glass areas are accented handsomely by liberal use of weather-resistant ENDURO Stainless Steel.

ENDURO is more than permanently attractive. It has no equal as an economical functional material. It offers innate beauty, strength, resistance to rust and corrosion, ease of cleaning, sanitation, and long life.

In Mercy Hospital, ENDURO has been used creatively for ventilators, coping, fresh air intakes, flashing, gravel stops, gutters and downspouts, sunshades, laundry chutes, signs, door and window frames. Even I-beams are shrouded with it. Interior equipment, of course, is largely stainless steel, too.

While the use of ENDURO in several of these applications temporarily is curtailed, Republic is ready *now* to work with you on any future development you may have in mind.

ENDURO is used for wall coping, flashing, gravel stops, ventilator, gutters and downspouts.

REPUBLIC STEEL CORPORATION
Alloy Steel Division · Massillon, Ohio
GENERAL OFFICES • CLEVELAND 1, OHIO
Export Department: Chrysler Building, New York 17, N.Y.

Republic
REPUBLIC STEEL
ENDURO STAINLESS STEEL

Other Republic Products include Carbon and Alloy Steels—Pipe, Sheets, Tubing, Lockers, Shelving, and Fabricated Steel Building Products

NEWS...

Northwestern University Lists Candidates for Degrees and Residency Appointments

EVANSTON, ILL.—The list of graduates from Northwestern's course in hospital administration, and those appointed to one-year residencies, has been announced by university officials. They are as follows:

Those receiving master's degrees included: Henry Amicarella, administrative assistant at Colorado General Hospital, Denver; Dr. Nestor M. Arreaza Colizza, to be administrator of a hospital in Valencia, Venezuela; Nils G. Axelson, administrative resident at East Orange General Hospital, East Orange, N.J.; Norma M. Barden, administrative assistant at Philadelphia General Hospital, Philadelphia; Harry A. Blythe, assistant superintendent of University of Chicago Clinics, in charge of operation of the Argonne Cancer Research Hospital; Benny T. Carlisle, administrator of a hospital in Crossville, Ky.; Marian F. Cipala, administrative resident at Jefferson-Hillman Hospital in Birmingham, Ala.

John C. Gettman, assistant administrator of Memorial Hospital of Sandusky County, Fremont, Ohio; Stanley E. Giese, administrator of Warren Hospital, Michigan City, Ind.; Dwayne L. Hall, administrator of City Hospital, Bowling Green, Ky.; Harry G. Higgins Jr., formerly business manager of Miami Valley Hospital, Dayton, Ohio; Waldo A. Hill, administrative assistant at Baylor University Hospital, Dallas, Tex.; Robert T. Jacobson, administrative resident at Baroness Erlanger Hospital, Chattanooga, Tenn.; Charles U. Letourneau, secretary of Council on Professional Practice, American Hospital Association.

Joseph A. Lilli, to be assistant administrator of Citizens General Hospital, New Kensington, Pa.; Raymond T. McHugh, administrative assistant at Herrick Memorial Hospital, Berkeley, Calif.; Freeman E. May, administrator of Le Bonheur Children's Hospital under construction at Memphis, Tenn.; Kenneth D. Moburg, administrative resident at Grace Hospital, Detroit; George D. Monardo, administrative resident at Los Angeles County Hospital, Los Angeles; Marvin W. Nichols, administrative assistant at Methodist Hospital, Sioux City, Iowa; Albin H. Oberg.

Ernest W. Quittmeyer, administrative resident at Passavant Memorial Hospital, Chicago; Ernest A. Ryberg, former administrator of Anna City Hospital, Anna, Ill.; Robert A. Sandahl, assistant administrator at Wausau Memorial Hospital, Wausau, Wis.; Donald F. Scalzo, assistant administrator at Evangelical Hospital, Chicago; Richard L. Sejnost, administrative assistant at Harper Hospital, Detroit; Carlos J. R. Smith, assistant administrator of Methodist Hospital, Memphis, Tenn.; Roy J. Weinzettel, assistant administrator of Mound Park Hospital, St. Petersburg, Fla.; Otis L. Wheeler; Med Wickham, Fifth Evacuation Hospital, U.S. Army, Fort Bragg, N.C.; Louise Wilkonson, administrator of San Jacinto Memorial Hospital, Baytown, Tex.

Lee W. Yothers, administrative resident at Research and Educational Hospitals, University of Illinois; Mortimer W. Zimmerman.

QUALIFIED LAST AUGUST

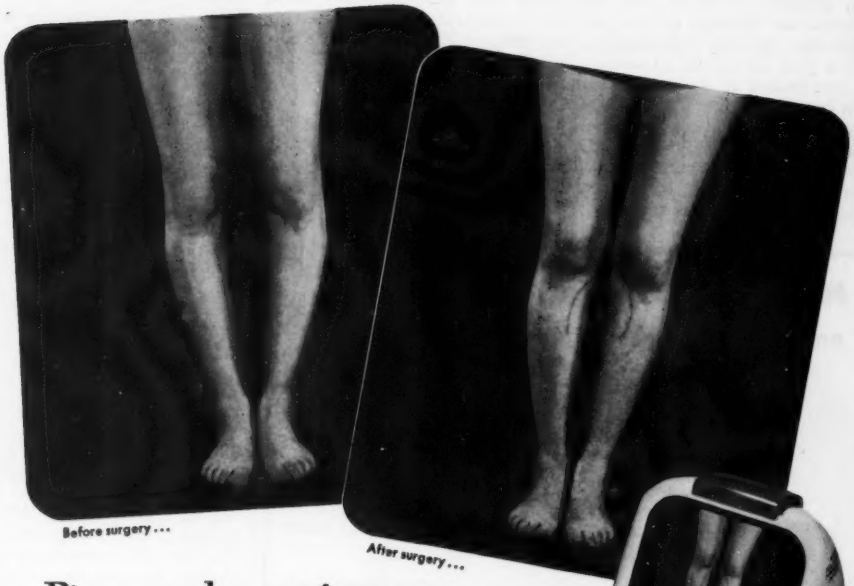
Also receiving their degree in June, although they qualified last August, were:

Maj. William L. Austin, Hospital Administration School, Brooke Army Medical Center, Fort Sam Houston, Tex. The Rev. J. Gordon Dandignac, administrator of Dickinson County Memorial Hospital, Iron Mountain, Mich.; Col. Jackson B. Dismukes, post surgeon and commanding officer, U.S. Army Hospital, Camp Polk, La.; Dr. Jose Gonzales-Mora, representative of the Hospital department, American College of Surgeons; Col. Louis H. Jobe Jr., with U.S. Army in Austria; Din Shiang Lien, graduate student at University of Illinois.

Col. Gordon F. McCleary, Hospital Administration School, Brooke Army Medical Center, Fort Sam Houston, Tex.; the Rev. Paul Kenneth Potter, chaplain in U.S. Navy; Mildred L. Recknagel, formerly assistant administrator, Springfield City Hospital, Springfield, Ill.

John B. Schroeder, business manager, Rock Island City Convalescent Home, Coal City, Ill.; Eugenie M. Stuart, assistant professor of hospital administration, University of Toronto, Toronto, Ont.; Col. Lester P. Veigel, consultant in hospital administration, Office of the Surgeon General, U.S. Air Force.

The two men who qualified for bachelor's degrees are Frank A. Lynch, manager of patient service, St. Luke's Hospital, Chicago, and James W.



Picture the patient

... *before and after*

Today it's common practice with many physicians and surgeons to document each significant case with photographs made before and after treatment.

Common practice, too, is to use a Kodaslide Table Viewer, Model A, when presenting such pictures—particularly to small groups. This convenient projection outfit (illustrated) includes screen, projector, and changer in one unit. It takes standard 35mm. or Bantam slides, produces a brilliant image up to 5¼x7¼ inches in a fully lighted room. Weighs only 11 pounds complete with sturdy case.

Also available: Kodaslide Table Viewer, 4X. It provides sharp, radiant images enlarged over four times. Ideal for arranging and editing.

For further details—see your nearest dealer or write:

EASTMAN KODAK COMPANY
Medical Division, Rochester 4, N. Y.

Kodak products for the medical profession include:

X-ray films, screens, and chemicals; electrocardiographic papers and film; cameras and projectors—still- and motion-picture; enlargers and printers; photographic film—full-color and black-and-white (including infrared); photographic papers; photographic processing chemicals; microfilming equipment and microfilm.

Serving medical progress through Photography and Radiography

Kodak
TRADE-MARK

NEWS...

Quinn, assistant administrator, Jefferson-Hillman Hospital, Birmingham.

Dr. Malcolm T. MacEachern also announced the following one-year administrative residency appointments, effective June 15, for the 33 students who have finished the academic portion of the course:

Herbert Abramson, Beth Israel Hospital, New York City; Thomas L. Askew, Mercy Hospital-Street Memorial, Vicksburg, Miss.; Edith May Beyer, Methodist Hospital, Houston, Tex.; Helen E. Chase, University of Iowa Hospital, Iowa City; Marshall Cherkas, Mount Sinai Hospital, Miami Beach, Fla.; Robert L. Denholm, Colorado General Hospital, Denver; Paul X. Elbow, Welborn Memorial Baptist Hospital, Evansville, Ind.

Lucille I. Fernleaf, St. Luke's Hospital, Chicago; Wellington Ming Foo, Grace Hospital, Detroit; Coleman H. Foote, St. Luke's Hospital, Chicago; Orrie L. Gilbert, Druid City Hospital, Tuscaloosa, Ala.; Robert C. Haskins, Passavant Memorial Hospital, Chicago; James C. Heidenreich, Herrick Memorial Hospital, Berkeley, Calif.; Emmett R. Johnson, East Texas Hospital Foundation, Tyler, Tex.; Paul H. Keiser, Wesley Memorial Hospital, Chicago; William J. Kramer, Mount Zion Hospital, San Francisco.

Ellis H. Lindhorst, Waverly Hills Sanatorium, Waverly Hills, Ky.; Oscar D. Luther, University of Michigan Hospital, Ann Arbor, Mich.; Edgar O. Mansfield, Mound Park Hospital, St. Petersburg, Fla.; Yeshwant M. Nilajgi, East Orange General Hospital, East Orange, N.J.; Anthony J. Perry, Decatur and Macon County Hospital, Decatur, Ill.; Harold L. Peterson, Baroness Erlanger Hospital, Chattanooga, Tenn.; Steven C. Pindiak, Orange Memorial Hospital, Orlando, Fla.

Jurral C. P. Rhee, charities office, Los Angeles County, Calif.; William R. Rundle, Youngstown Hospital, Youngstown, Ohio; Elizabeth J. Schrei, Galesburg Cottage Hospital, Galesburg, Ill.; Richard Shedlovsky, Malden Hospital, Malden, Mass.; Charles Showalter, Orange Memorial Hospital, Orlando, Fla.; Elbert B. Sledge, Baptist Memorial Hospital, Memphis, Tenn.; Paul T. Sodt, Memorial Hospital of Sandusky County, Fremont, Ohio, Doyle R. Taylor, Bethany Hospital, Kansas City, Kan.; George F. Walls, Ohio Valley General Hospital, Wheeling, W. Va., and Anne M. Whelan, Women and Children's Hospital, Chicago.

Clark and Smelzer Attend I.H.F. Meeting

NEW YORK.—The two new voting delegates for the American Hospital Association at the International Hospital Federation meeting held July 15 to 21 at Brussels, Belgium, were James Russell Clark, director, Brooklyn Hospital, Brooklyn, N.Y., and Dr. Donald C. Smelzer.

The International Hospital Federation held its seventh international congress this year under the patronage of Her Majesty Queen Elizabeth of Belgium. The congress considered the care of the chronic sick and the aged, exchanged international points of view on national and regional hospital planning; hospital construction and maintenance; administration and finance, and new developments in medical, nursing, social and indigent care.

"Over 50% reduction in replacement costs due entirely to the use of dinnerware molded of

MELMAC® PLASTIC"

—reports the well known Hubbard House chain

Mr. Ronald K. Jetmore, vice president of Hubbard House, Inc., enthusiastically endorses Restraware, molded of MELMAC, *by Applied Plastics Division of Keystone Brass Works.*

"As you know," says Mr. R. K. Jetmore, vice president of the famous Hubbard House chain, "we keep a very accurate record of replacement costs, and we find that dinnerware molded of MELMAC, by itself, has reduced our tableware replacement costs by over 50% . . . a substantial item, as every restaurant man is agreed.

"After some two years we are even more sold on it than we were originally. It is well accepted by our customers, and we are especially pleased because its quietness eliminates much of the dish noise prevalent in counter service and dishwashing machines."

This is just *one* of many enthusiastic endorsements of dinnerware molded of MELMAC plastic. And it's one more reason why it will pay you, too, to insist that your supplier give you full details about MELMAC plastic tableware.

AMERICAN *Cyanamid* COMPANY

PLASTICS DEPARTMENT

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

In Canada: North American Cyanamid Limited, Royal Bank Building, Toronto, Ontario, Canada.

NEWS...

Assignments for Residencies Announced by Columbia Course in Administration

NEW YORK. — Assignments for administrative residencies for 1951-52 have been announced by the School of Public Health, Columbia University, as follows:

Dr. Carlos Barrena, Lebanon Hospital, New York; Patricia M. Brandt, Syracuse Memorial Hospital, Syracuse, N.Y.; Maurice Bull, St. Barnabas Hospital for Chronic Diseases, New York; Warner Byars, Harper Hospital, Detroit; Dr. Tomas Calvo, Bureau of Health and Hospitals, Denver; Leon Carson, Robert Packer Hospital, Sayre, Pa.

Russell M. Drumm, Greenwich Hospital, Greenwich, Conn.; Efrain Flores, Morrisania City Hospital, New York; Dr. David Garcia, University of the Philippines Health Service, Diliman, Zuezon City, P.I.; Edward Gooby, Grace Hospital, Detroit; Lyle Hartford, University of Colorado, Department of Medicine, Denver; John Keene, Muhlenberg Hospital, Plainfield, N.J.; Harold Koach, Youngstown Hospital, Youngstown, Ohio; Thomas Larkin, Reading Hospital, Reading, Pa.

John McDonald, Harper Hospital, Detroit; Frank Monkus, University of Pennsylvania Hospitals, Philadelphia; Joseph K. Owen, Medical College of Virginia, Hospital Division, Richmond, Va.; William P. Ryan Jr., Hartford Hospital, Hartford, Conn.; John Soyke, Graduate Hospital, University of Pennsylvania, Philadelphia; Joseph V. Terenzio, Knickerbocker Hospital, New York; Arcadio Torres, Veterans Administration Center, San Patricio Hospital, San Juan, P.R.; Nicholas Verrastro, Waterbury Hospital, Waterbury, Conn.

Richard Ward, Presbyterian Hospital, New York; William Worcester Jr., New York Hospital, New York, and Dr. Carlos Zamarripa, Morrisania Hospital, New York.

New York to Open Narcotic Center for Teen-Age Patients

NEW YORK.—City officials here have announced that a narcotics treatment and rehabilitation center with facilities for 150 teen-age drug users will be opened on North Brother Island in the East River during the fall.

Mayor Vincent R. Impellitteri gave his approval to a resolution submitted by the board of hospitals' special subcommittee on narcotics. The resolution urged that Riverside Hospital on the island "be placed into use at the earliest opportunity" as a "single facility" for "appropriate care, treatment and follow-up service to all teen-age drug users."

The mayor also instructed the commissioner of hospitals, Dr. Marcus D. Kogel, "to proceed with the necessary steps" to reclaim the island's hospital facilities. It has been used by the state for the last five years as an emergency housing project for students attending educational institutions in New York City.

The main building on the island will require a staff of 200, Dr. Kogel reported, including psychiatrists, psychologists, vocational guidance and social service workers.

"It has not been demonstrated yet that there are 150 young addicts who need active treatment," he said. "Nevertheless, we want to take care of anyone

(*Continued on Page* 158)

PROFESSIONAL SUPPLIES

Last month *The Modern Hospital* told about sharp increases in hospital inventories. It's probably a good thing to have a safe cushion of all essential supplies. However, big inventories cost you money. Wise hospital administrators have learned to keep inventories safe but in balance by using *Hospital Purchasing File*. In this volume they have always before them buying information on a wide range of products—to help them buy what they need as they need it.

Look especially at Section GB where you will find excellent catalogs of medical and surgical instruments and supplies. Several of the biggest companies have filed in this section extensive catalogs of things you need and use every day. Be sure you are familiar with it. Be sure your OR and OB supervisors are familiar with it.

Here are manufacturers of general professional supplies who have filed information in the current Hospital Purchasing File to make it easier for you to buy:

SECTION GB

Aloe Co., A. S.
Bard-Parker Co., Inc.
Bauer & Black Division of The Kendall Co.
Becton, Dickinson & Co.
Berbecker & Sons, Inc., Julius
Bishop & Company, Platinum Works, J. Medical Products Division
Chesebrough Mfg. Co., Cons'd., Professional Products Division
Conductive Hospital Accessories Corp.
Crescent Surgical Sales Co., Inc.
Davis & Geck, Inc.
Edison Chemical Co.
Ethicon Suture Laboratories, Inc.
Felters Co.
Gudebred Bros. Silk Co., Inc.
Hodgman Rubber Co.
MacGregor Instrument Co.
Meinecke & Co., Inc.
Mueller & Co., V.
Perm-Aseptic Corp.
Physicians & Hospitals Supply Co., Inc.
Pioneer Rubber Co.
Plymouth Rubber Co., Inc.
Presco Co., Inc.
Pyramid Rubber Co.
Seamless Rubber Co.
Sklar Mfg. Co., J.
Vita Needle Co.
Weck & Co., Inc., Edward
Wocher & Son Co., Max

NEWS...

who possibly may be addicted. We expect to get referrals from schools, parents and all sorts of agencies. Probably 90 per cent of our cases will be teenagers who are using drugs but have not become addicts—yet."

Doctors Oppose Providing 16,000 New V.A. Beds

WASHINGTON, D.C.—Dr. Robert Collier Page, chairman of the National Doctors' Committee for Improved Federal Medical Services, has charged that the projected construction of 16,000 new Veterans Administration hospital beds was wasteful because there were no patients for them or staffs to tend them.

Dr. Page, acting as spokesman for the group which is affiliated with the Citizens Committee for the Hoover Report, made the complaints in letters to Vice President Alben W. Barkley and Speaker Sam Rayburn of the House of Representatives.

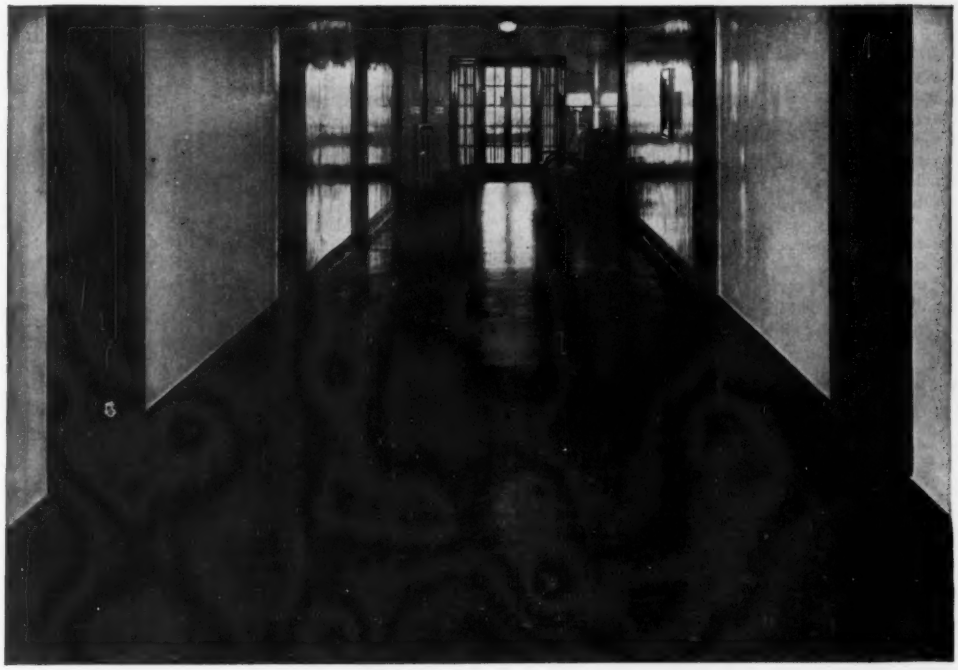
The measure, now under consideration by the Senate following House approval, would cost the nation $335,000,000, Dr. Page said, plus another $60,000,000 annually for maintenance.

Some 10,000 beds are empty now anyway, he declared, and the V.A. already has 108,400 beds, and 131,000 more are being built or designed. It cannot obtain staffs to take care of more than a total of 228,000 and it does not want the extra 16,000.

The doctors' committee also said that "no one official under the President is charged with seeing to it that every available bed is put to use before new ones are built."

CSI-52 for Thermometers

WASHINGTON, D.C.—The commodity standards division of the U.S. Department of Commerce has announced a new commercial standard for clinical thermometers, according to a report released here last month. The new standard, which will become effective Jan. 16, 1952, simplifies the testing of clinical thermometers and clarifies some previous requirements, it was explained. Initially proposed by manufacturers and approved after study by the American Hospital Association and various government agencies and consumer representatives, the standard will be known as "Clinical Thermometers, 4th Edition, Commercial Standard CS1-52."



A Tile-Tex Floor is *On The Job* Sooner than you think

It doesn't take long to get Tile-Tex* flooring on the job.

Tile-Tex is amazingly quick to install. It goes down easily over old or new sub-floors . . . and into *immediate* use. No delays . . . no closed off areas after installation.

And when you *have* installed Tile-Tex, you'll have flooring that gives exactly the kind of service you've always wanted!

You'll have resilient floors. Quiet floors.

You'll have *attractive* floors. Lustrous. Close-textured. Floors with straight-fitting, snug joints.

You'll have colorful floors, too—if you want them. For Tile-Tex comes in a wide range of clear, true colors. Plain or marbleized. Warm or cool, stimulating or restful.

You'll have floors that are highly resistant to wear. Floors that put in the hours—the months—the *years*, without looking tired and worn.

You'll have floors that are sanitary . . . easy to clean and to *keep* clean. Floors that simply require daily sweeping, periodic mopping or waxing.

And because of tile-at-a-time installation, you'll enjoy exceptionally low maintenance costs when repairs *do* become necessary.

So call in your Tile-Tex contractor for complete information and free estimates.

THE TILE-TEX DIVISION, The Flintkote Company, 1234 McKinley Street, Chicago Heights, Ill.

The Flintkote Company of Canada, Ltd., 30th Street, Long Branch, Toronto, Canada.

MEET US IN ST. LOUIS IN BOOTH 316
AT THE AMERICAN HOSPITAL ASSOCIATION CONVENTION, SEPT. 17-20.

*REGISTERED TRADEMARK, THE FLINTKOTE COMPANY

Asphalt TILE-TEX Tile

TILE-TEX...*The Quality Asphalt Tile*

NEWS...

Nursing Schools Half Empty

NEW YORK.—Mrs. Ethel G. Prince, executive secretary of the Nurses Association of the Counties of Long Island, disclosed that Long Island's schools for nurses find their classes only half filled for the spring term.

Despite greater demands for nurses only 164 places were filled by student nurses of the possible 295 openings in the eight schools.

The total student capacity of all Long Island schools is more than 800.

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, St. Louis, Sept. 17-20.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 16-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, St. Louis, Sept. 15-17.

AMERICAN COLLEGE OF SURGEONS, San Francisco, Nov. 5-9.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Shirley-Savoy Hotel, Denver, Sept. 4-8.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 17-20.

AMERICAN PHARMACEUTICAL ASSOCIATION, Buffalo, N.Y., Aug. 26-31.

AMERICAN PUBLIC HEALTH ASSOCIATION, San Francisco, Oct. 29-Nov. 2.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 16-19.

COMMITTEE ON WOMEN'S HOSPITAL AUXILIARIES, Statler Hotel and Kiel Municipal Auditorium, St. Louis, Sept. 17-20.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Dec. 3, 4.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Nov. 14, 15.

INDIANA HOSPITAL ASSOCIATION, Jefferson Hotel, St. Louis, Sept. 19.

KANSAS HOSPITAL ASSOCIATION, Topeka, Nov. 8, 9.

MARYLAND - DISTRICT OF COLUMBIA - DELAWARE HOSPITAL ASSOCIATION, Statler Hotel, Washington, D.C., Nov. 26, 27.

MISSISSIPPI HOSPITAL ASSOCIATION, Heidelberg Hotel, Jackson, Oct. 11, 12.

MONTANA HOSPITAL ASSOCIATION, Billings, Oct. 11, 12.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Palmer House, Chicago, Oct. 3-4.

NEBRASKA HOSPITAL ASSOCIATION, Paxton Hotel, Omaha, Nov. 15, 16.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Tulsa Hotel, Tulsa, Nov. 1, 2.

RHODE ISLAND HOSPITAL ASSOCIATION, St. Joseph's Hospital, Providence, Sept. 13.

WORLD MEDICAL ASSOCIATION, Stockholm, Sweden, Sept. 15-20.

1952

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Statler, Cleveland, Feb. 21, 22.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 14-16.

ASSOCIATION OF WESTERN HOSPITALS, San Francisco, May 12-15.

MID-WEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 23-25.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Statler Hotel, Cleveland, Feb. 20-21.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 24-26.

OHIO HOSPITAL ASSOCIATION, Cleveland Hotel, Cleveland, March 31-April 3.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 16-18.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 20-22.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

WISCONSIN HOSPITAL ASSOCIATION, Schroeder Hotel, Milwaukee, Feb. 14.

Fewer Hands

DO MORE WORK WITH

DIXIE CUPS

'Round-the-clock food service in busy hospitals and institutions is a big job. One way to make it an *easier* job for all concerned is by using Dixie Cups and Food Containers. *Fewer hands do more work* when Dixies are used. Dixies save on dishwashing costs . . . save on dishwashing time. There is no waiting, no delay . . . food distribution is faster, more economical. Less help . . . less time is needed for *better* kitchen to bedside service. No-return, single-use Dixie Cups and Food Containers save time, labor in every phase of food service.

WHY HOSPITALS SHOULD USE DIXIE PAPER SERVICE:

FASTER . . . . Food service is streamlined because Dixies are always ready for instant use. Trays are lighter . . . fewer nurses' aides can handle more trays.

QUIETER . . . No disturbing clatter and rattle of dishes when Dixies are used. No nerve-wracking crash of dropped crockery or glasses.

SAFER . . . . . Dixies provide constant protection from mouth-borne infection . . . eliminate dangers of improperly washed dishes.

THRIFTIER . . Dixies save time, labor . . . eliminate many man-hours of dishwashing. Less help is needed to distribute food. Food savings can be effected through more rigid portion control.

For complete information on paper service, write Dixie Cup Company, Easton, Pa.

There's a Dixie Cup or Food Container for every need:

COLD DRINK CUPS for water, fruit and vegetable juices.

COLD DRINK CUPS for milk and soft drinks.

HOT DRINK CUPS for coffee, tea, cocoa.

FOOD CONTAINERS for soups, stews, main dishes

ICE CREAM CUPS for pre-packed serving of ice cream.

DESSERT DISHES for ice cream, stewed fruits, and puddings.

"Dixie" is a registered trade mark of the Dixie Cup Company

DIXIE CUP COMPANY

EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., FT. SMITH, ARK., BRAMPTON, CANADA

ABOUT PEOPLE

(*Continued From Page 93*)

V. Foster has been appointed director of Gowanda State Hospital, Gowanda, N.Y. Dr. Terrence, who was formerly associated with the Brooklyn State Hospital, Brooklyn, N.Y., as assistant director, has been assistant professor of clinical psychiatry at New York State University Medical School in New York City. He is a diplomate of the American Board of Psychiatry and Neurology, president of the New York Society of Clinical Psychiatry and a fellow of the American Psychiatric Association. Dr. Foster's former position was as associate director of Central Islip State Hospital, Central Islip, N.Y. He has been a diplomate of the National Board of Medical Examiners since 1932 and was designated by the Department of Mental Hygiene as medical inspector in 1946 and 1948. During World War II and again during recent months he has served as examining neuropsychiatrist at the army recruiting and induction center in New York City. The former director at Rochester, **Dr. O. Arnold Kilpatrick,** has been transferred to Hudson River State Hospital, Poughkeepsie, N.Y., and **Dr. Charles Buckman,** the former director at Gowanda, is now assistant commissioner of mental hygiene for the state of New York.

R. K. Bolinger

Ray K. Bolinger has been appointed administrator of the Robert Packer Hospital in Sayre, Pa., succeeding **Howard E. Bishop,** who retired July 1 after 39 years at that hospital.

Mr. Bolinger received his bachelor's degree in business administration from Indiana University and his master's degree in hospital administration from Northwestern University. He served two and one-half years as assistant administrator to **L. W. Hilton** at the Jackson Park Hospital in Chicago and was assistant to Mr. Bishop at the Robert Packer Hospital for two and one-half years.

A member of the American College of Hospital Administrators, Mr. Bolinger is a personal member of the American Hospital Association and a member of the Hospital Association of Pennsylvania.

Stanley F. Masson, who received his master's degree in hospital administration from the University of Minnesota and served his administrative residency and later became assistant administrator at Denver General Hospital, has been appointed assistant administrator of the Robert Packer Hospital.

Lester Tuck has been appointed administrator of the new Felix Long Memorial Hospital at Starkville, Miss. Before he went to Starkville, Mr. Tuck held the post of assistant administrative officer of the Mississippi Commission on Hospital Care.

David E. Olsson, acting administrator of San Jose Hospital, San Jose, Calif., since the death of **Willim P. Butler,** has been named administrator. Mr. Olsson was assistant administrator for nearly two years preceding Mr. Butler's death. Before that he was an administrative resident at the hospital on assignment from the University of Minnesota. **Frederic C. LeRocker,** who has been administrative resident at General Hospital, Vancouver, B.C., for a year following his graduate work at the University of Minnesota, has been chosen as assistant administrator of the San Jose Hospital.

Frank E. Kimble, who served for 21 years as business manager of the Red Cross Hospital at Salida, Colo., is now administrator of the new Hardy Wilson Memorial Hospital at Hazlehurst, Miss.

B. Lee Mootz has assumed his duties as administrative resident at Aultman Hospital, Canton, Ohio. Mr. Mootz will receive a master's degree in business administration from the University of Chicago upon completion of the residency.

Dr. Mark A. Freedman has accepted the office of executive director of the Jewish Hospital of Brooklyn, N.Y., and will assume his new duties September 1. Dr. Freedman is at present the associate director of Montefiore Hospital, New York City.

Dr. Edward S. Post is the new manager of the Veterans Administration hospital at Sheridan, Wyo.; **Dr. George S. Littell** is head of the V.A. hospital at Dallas, Tex., and **Dr. Morris C. Thomas** is the new manager of the V.A. hospital soon to be completed in Madison, Wis. Dr. Post, the former manager of the V.A. hospital at Fort Custer, Mich., succeeds **Dr. Victor H. Bean** at Sheridan. Dr. Bean has been transferred to the V.A. hospital at Alexandria, La. Dr. Littell is the successor of **Dr. Frederick R. Eastland** at Dallas. Dr. Littell had been manager of the V.A. hospital at Wichita, Kan.

C. H. Linville, administrator of Yuma General Hospital, Yuma, Ariz., has resigned to accept the post of administrator of Fresno Community Hospital, Fresno, Calif. Mr. Linville is president of the Arizona Hospital Association.

Harry Payne, former administrator, Houston Tuberculosis Hospital, Houston, Tex., has assumed the administratorship of the Ector County Hospital, Odessa, Tex., succeeding **Clarence C. Gibson.** Mae Aldrich has been named to the position at Houston.

John Brown has resigned as administrator of Middlesex General Hospital, New Brunswick, N.J., to become head of Rockford Memorial Hospital, Rockford, Ill. Before going to Middlesex, Mr. Brown was assistant administrator at Samaritan Hospital, Troy, N.Y.

Robert B. Lloyd has resigned the post of administrator of the Texas and Pacific Employees Hospital, Marshall, Tex., to assume new duties as administrator of St. David's Hospital, Austin, Tex.

Kurt H. Nork has assumed his duties as assistant director, University Hospital, University of Maryland, Baltimore, and director of its outpatient department. Mr. Nork is a graduate from Columbia College and received his master's degree in hospital administration from the School of Public Health, Columbia University. He completed his administrative residency last year at the Society of the New York Hospital, New York City.

Austin J. Evans has become business administrator of the Mental Health Institute, Independence, Iowa. The institution is the former Independence State Hospital. Mr. Evans received a master of science degree from Yale University and has served for two years as administrative associate at the State University of Iowa Hospitals, Iowa City. He is a personal member of the American Hospital Association and the Iowa Hospital Association.

W. L. Simon

William L. Simon, a graduate of the Duke University School of Hospital Administration, has been named assistant administrator of the Hubbard Memorial Hospital at Nashville, Tenn.

SELECTED

for fine buildings everywhere!

CORBIN

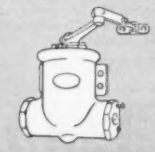
"900" SERIES UNIT LOCKS AND LATCHES

For today's buildings there is no finer lock, *no wiser choice*, than Corbin "900" Series Unit Locks and Latches.

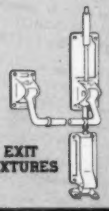
These fine locksets are assembled by skilled Corbin lockmakers in one piece, with knobs and escutcheons attached; they are shipped as a unit, installed as a unit. The result is a lock that is easily and economically installed and requires little or no maintenance . . . a lock that is unsurpassed for its smooth action and *lasting* security.

For hospitals, schools, office buildings, apartments and residences, Corbin "900" Unit Locks and Latches are a wise and time-tested choice. They are made in functions and finishes to meet every need.

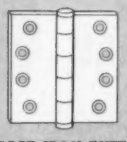
Other fine-quality CORBIN Hardware includes:



DOOR CLOSERS



EXIT FIXTURES



CAST IRON BUTTS

FLUSH BOLTS

P. & F. Corbin Division
The American Hardware Corporation
New Britain, Connecticut, U.S.A.

GOOD BUILDINGS DESERVE GOOD HARDWARE

CORBIN


R. M. Jones

Robert M. Jones, administrative resident at Columbia Hospital, Milwaukee, has been named administrative assistant there. Mr. Jones received his bachelor's degree in industrial management from the University of Wisconsin and his master's degree in hospital administration from Columbia University.

Joseph W. Hinsley has been appointed administrator of the Lake Charles Memorial Hospital, Lake Charles, La. He was formerly assistant director of the Touro Infirmary, New Orleans.

Clarence William Bushnell has been appointed administrative assistant for professional services at the Massachusetts Memorial Hospitals, Boston. Administrative resident at the hospital for the last year, he received the master of public health degree from the Yale University course in hospital administration in June.

Mrs. Trenton G. Shelton, R.N., formerly connected with the nursing staff of the North Mississippi Community Hospital in Tupelo, has been named administrator of the Covington County Hospital, Collins, Miss.


Sylvester Schroeder

Sylvester Schroeder, assistant director of Michael Reese Hospital, Chicago, has been appointed director of clinics and assistant to the medical director at St. Luke's Hospital, Chicago, succeeding **Vernon Seiffert.** Mr. Schroeder was on the staff at Michael Reese for 12 years, and was appointed assistant director in 1947.

Department Heads

John R. Kinsey is the new public relations director at Wesley Memorial Hospital, Chicago. A former newspaper man, Mr. Kinsey was at one time associate editor of *Popular Mechanics* and also directed public relations activities for Westinghouse Appliance Division. More recently, he was a member of the public relations staff at Northwestern University.

Louis Gdalman recently became the director of pharmacy at St. Luke's Hospital, Chicago. He previously was the director of pharmacy at Michael Reese Hospital in Chicago and before that the assistant director of pharmacy at St. Luke's for almost 20 years. He is the former secretary-treasurer of the Chicago chapter of the American Pharmaceutical Association; the former president of the Illinois chapter of the American Society of Hospital Pharmacists, and a fellow of the American Association for the Advancement of Science.

Roland H. Main succeeds **Sol. Singerman** as purchasing agent at Knickerbocker Hospital, New York City. Mr. Main formerly was associated with Stamford Hospital, Stamford, Conn. Mr. Singerman's new position is with Michael Reese Hospital, Chicago.

Mrs. Minnie Tulipan, the former director of welfare at Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N.Y., has been appointed to the position of administrator of welfare. **Mrs. Florence Stein,** formerly medical social consultant of the New York City Department of Health, has been named director of social service at the hospital.

Muriel Carbery is the new associate director of the nursing service of the New York Hospital, New York City. Also an assistant professor of nursing at Cornell University-New York Hospital School of Nursing, Miss Carbery

succeeds **Bessie A. R. Parker,** who has retired after 33 years in the profession. Miss Carbery, who holds the rank of lieutenant-colonel in the army nurse corps reserve, served during World War II in the Southwest Pacific as chief nurse, operating room, Ninth General Hospital, and principal chief nurse, Fourth General Hospital.

Laura May Beery, R.N., formerly assistant chief of the nursing service of the Veterans Administration Hospital at Lyons, N.J., has been appointed director of nursing education and nursing service at Chestnut Hill Hospital, Philadelphia, succeeding **Katherine Clarke, R.N.,** the former director. Miss Clarke has been granted a scholarship by the board of trustees of the hospital to continue her academic work in nursing education.

Laura M. Grant has been promoted to a full professorship at Yale University. Her position now is that of professor of nursing administration.

Mildred E. Newton, R.N., assistant dean of the University of California School of Nursing, is the new head of Ohio State University's school of nursing. Miss Newton, who succeeds **Frances McKenna,** R.N., will hold the rank of professor of nursing education and director of the school. Previously, she served at Pasadena Hospital and Junior College as instructor and later as director of the school. Miss Newton, who has written many articles for professional journals in the fields of nursing and hospital administration, has collaborated in the authorship of two textbooks, "Principles and Practices of Surgical Nursing," and "Nursing, an Art and a Science."

Gertrude M. Stier, director of nursing education at Mercy Hospital School of Nursing, Urbana, Ill., has been chosen as coordinator of nursing education for the Illinois State Department of Registration and Education, succeeding **Elizabeth H. Wright,** who resigned. **Noble J. Puffer,** director of the department, said Miss Stier would resign her position as chairman of the Illinois Board of Nurse Examiners when she assumed her new position.

Miscellaneous

Mrs. Elizabeth D. Simmerman has been elected executive secretary of the Kentucky Hospital Association by the board of trustees. Mrs. Simmerman is the hospital consultant for the division of hospital services in the Kentucky State Department of Health.

Stephen J. Cushing of Brooklyn, N.Y., has assumed the presidency of the state Knights of Columbus Hospital Association, succeeding **Hugh A. Doyle** of New Rochelle, N.Y. The association operates the tuberculosis program for members at Gabriels, N.Y.

Katherine F. Lenroot's resignation as chief of the Children's Bureau of the Federal Security Agency has been accepted by President Truman. To succeed her President Truman nominated **Dr. Martha M. Eliot,** assistant director of the World Health Organization and formerly associate chief of the Children's Welfare Organization. Miss Lenroot, who has served the bureau for 36 years, served as president of the National Conference of Social Work in 1935. Successively, she also served as executive secretary of the White House Conference on Children in Democracy; adviser to American delegates at the 1945 International Labor Organization conference in Paris; secretary to the United Nations' temporary social committee, and American member of the executive committee of the International Children's Emergency Fund of the U.N.

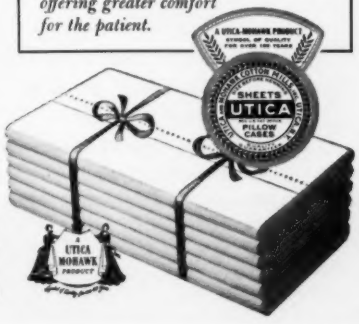
Marion L. Fox, R.N., has been appointed to the staff of the American Hospital Association in the newly created

Jefferson Medical College Hospital and Medical Center, Philadelphia

Seventh oldest...growing still

This massive block, at Tenth and Walnut Streets, Philadelphia, is the nucleus of Jefferson Medical College and Hospital. Jefferson is the second largest medical school and third largest voluntary hospital in the nation. Jefferson's 6,165 living alumni constitute the nation's largest group of graduate physicians. The hospital, last year, admitted 22,691 patients to its 1,100 beds and had 209,273 outpatients' visits to its twelve-story Curtis Clinic.

• To maintain this distinguished medical service, utmost care must be taken in all purchasing, to meet rigid standards of long service. Utica Sheets, purchased by this hospital, meet these exacting requirements, as well as offering greater comfort for the patient.



UTICA SHEETS

WOVEN EXTRA STRONG . . . TO WEAR EXTRA LONG

UTICA AND MOHAWK COTTON MILLS, INC., UTICA 1, NEW YORK

Selling Agents: Taylor, Pinkham & Co., Inc., 55 Worth Street, New York 13, N.Y. 300 West Adams Street, Chicago 6, Ill. • 605 Market Street, San Francisco 5, Cal. 1011 Chestnut Street, Philadelphia, Pa. • 814 Fidelity Building, Dallas 2, Texas

post of nursing specialist. Miss Fox's experience includes positions as head nurse, operating room supervisor, assistant director of nursing service and director of school of nursing. She is now chief of nursing service at the Veterans Administration Hospital at New Orleans.

Philip A. Austin is the new nursing and maternity home consultant for the Washington State Department of Health. A graduate of Northwestern University's course in hospital administration, Mr. Austin took his administrative residency at St. Barnabas Hospital for Chronic Disease, New York City, under **Dr. A. P. Merrill.** He has had 15 years' experience in the nursing home field.

Dr. Bert Caldwell, formerly executive secretary of the American Hospital Association, is now a patient in the Alexian Brothers Hospital, Signal Mountain, Chattanooga, Tenn.

Virgil A. Halbert, formerly special hospital administrative assistant, U.S. Public Health Service Hospital, Staten Island, N.Y., has been named acting administrative officer, U.S. Public Health Service Hospital, Baltimore.

Mr. Halbert served in hospital administrative assignments with the air force and as commanding officer of jointly operated air force-American Red Cross rest home stations during World War II. He is a graduate of Columbia University course in hospital administration and served an administrative residency at Grasslands Hospital, Valhalla, N.Y.

Trustees

Willard G. Hampton has been elected a trustee of Brooklyn Hospital, Brooklyn, N.Y. Vice president of the New York Telephone Company, he is a member of the Brooklyn chapter of the American Red Cross and the Manhasset Community Chest.

Raymond P. Sloan, editorial director of The MODERN HOSPITAL, has been elected to the board of trustees of Colby College, Waterville, Me.

Deaths

Lt. Col. Neil Francis MacDonald, U.S. Public Health Service (Ret.) and former director of distribution of surplus hospitals and hospital supplies, died recently at Palo Alto, Calif. Colonel MacDonald, who received his master's degree in hospital and business administration from the University of Chicago, served with the United Nations Relief and Rehabilitation Administration in the Middle East and Balkan areas as a hospital consultant during World War II. A fellow of the American Institute of Chemists, he was a member of the American College of Hospital Administrators, American Hospital Association, Association of Western Hospitals and Illinois Hospital Association.

Edith B. Irwin, who served as administrator of Westmoreland Hospital, Greensburg, Pa., for 25 years before her retirement this year, died recently. She had been a patient in the hospital for three months. Active in nursing personnel work during World War I, Miss Irwin was a member of the regular army nurse corps and became chief nurse of the University of Pennsylvania Unit, U.S.A. Base Hospital No. 20. She was later sent to Chatel-Guyon, France, where she spent 11 months. Other positions Miss Irwin held include the directorship of nurses, Women's College, Philadelphia, and superintendency of the Columbia Hospital, Wilkinsburg, Pa. She was a fellow of the American College of Hospital Administrators, Hospital Associa-

tion of Pennsylvania and the Hospital Conference of Pittsburgh. At one time she was also vice president of the American Hospital Association.

Dr. Ludvig Hektoen, internationally famous for his research work in pathology and immunology, died recently in Chicago. Dr. Hektoen was credited with the discovery of coronary thrombosis and he was a pioneer in blood research that paved the way for the present-day use of transfusions. The author of several books and many papers on pathology and bacteriological research, Dr. Hektoen received the distinguished service medal of the American Medical Association in 1942, and the gold-headed cane of the Association of American Pathologists and Bacteriologists in 1944. He was professor emeritus at Rush Medical College; the first chairman of the department of pathology at the University of Chicago Medical School, and president emeritus of the Chicago Tumor Institute.

Dr. Bert W. Caldwell, executive secretary of the American Hospital Association from 1927 to 1942, died on July 26 at Beloit Memorial Hospital, Beloit, Wis. He was 76 years old. Dr. Caldwell was graduated by Barnes Medical College in 1898 and practiced medicine in St. Louis for several years. He was in charge of hospitals in the Isthmus of Panama for the Isthmian Canal Commission during the construction of the canal. In 1915 he was a member of the Rockefeller Red Cross Commission to the Balkans, and later in World War I was attached to the American Embassy in Berlin as inspector of allied prison camps in Germany. Following the war he became administrator of Allegheny General Hospital, Pittsburgh, and later of the State University of Iowa Hospitals and the Municipal Hospital of Tampa, Fla. His long service with the American Hospital Association covered a period of great growth in membership, and he became the first editor of *Hospitals*.

Correction

In the July issue it was erroneously reported that **Robert Sandahl** had succeeded **Olive Graham** as administrator of the Wausau Memorial Hospital, Wausau, Wis. Mr. Sandahl was appointed assistant administrator, and Miss Graham continues in her position of administrator.

Dwayne L. Hall, administrator of City Hospital, Bowling Green, Ky., is a graduate of the program in hospital administration at Northwestern University. In the announcement of his appointment which appeared in The MODERN HOSPITAL for July, it was incorrectly stated that Mr. Hall was a graduate in hospital administration of the University of Denver.

Massachusetts Raises Payments for Indigents

BOSTON. — A bill providing for increased payments for hospital care of indigent patients was passed by the state legislature and signed by Governor Dever here last month, according to an announcement released by the Massachusetts Hospital Association. The new rate will become effective October 1, an association bulletin said, and will bring hospitals an estimated $640,000 annually in additional payments for indigent care.

The association originally sponsored a bill which provided for payment of actual hospital costs, it was explained. This was amended by the ways and means committee of the state house of representatives to include a $12 ceiling on per diem payments—a $2 increase over the ceiling established in 1949.

NEWS...

Johns Hopkins Has Hospital-Public Health Course

BALTIMORE.—A course of study has been inaugurated at Johns Hopkins University with the dual purpose of acquainting the students in various fields of public health with the subject of hospitals and of providing training for those wishing to specialize in the administration of hospitals or allied activities.

In addition to the school's basic courses in public health, specialized training is provided by four special courses in hospital administration, plus different combinations of supplementary training. These vary from short administrative projects within Johns Hopkins Hospital to research projects of a year or more in combination with administrative residencies in Johns Hopkins Hospital or other Baltimore hospitals.

Physicians who wish to specialize in hospital administration will be required to meet the basic requirements for the master of public health degree, to complete the four hospital administration courses, and to take special work in hospitals during the three months following their academic studies.

Other students will be accepted as candidates for the degree of master of science in hygiene. They will be required to spend two academic years, the first year devoted largely to prescribed courses of study, the courses varying according to type of preliminary preparation and the needs and wishes of the student. During the second year research activities will be conducted under school direction, combined with periods of administrative experience in the school's hospital or another Baltimore hospital. A thesis and written examination are required at the end of the second year.

One or two physicians who have completed the master of public health requirements may be accepted as candidates for the degree of doctor of public health, and one or two other students who have completed the master of science in hygiene program or its equivalent may be candidates for the degree of doctor of science in hygiene.

The June graduates in hospital administration from the School of Hygiene and Public Health include: Wilbur Charles Anderson, Ph.G., B.Sc., M.Sc., M.P.H., Philadelphia; Jane Carol Baldwin, B.A., M.P.H., Maryland; Barry Bowers, B.E., M.P.H., New Jersey; Clifford Stanley Johnson, B.S., M.P.H., District of Columbia, and Rafael Lorca, M.D., C.P.H., M.P.H., Chile.

Residencies Announced for Minnesota Graduates

MINNEAPOLIS.—The 26 graduates of the University of Minnesota's course in hospital administration will serve their one-year residencies in the following institutions:

John H. Daniels, Lewistown Hospital, Lewistown, Pa.; Vance C. Demong, Ancker Hospital, St. Paul, Minn.; Bright M. Dornblaser, Mary Fletcher Hospital, Burlington, Vt.; Donald E. Gilbert, Genesee Hospital, Rochester, N.Y.; Oren W. Govier, Vancouver General Hospital, Vancouver, B.C., Canada; David H. Hitt, research fellow, school of public health, University of Minnesota; James D. Harvey, Hillcrest Memorial Hospital, Tulsa, Okla.; Vernon L. Harris, Northwestern Hospital, Min-

neapolis; Charles F. Harrienger, Highland Hospital, Rochester, N.Y.; James W. Knight, St. Luke's Hospital, Duluth, Minn.; John W. Norton, Rhode Island Hospital, Providence, R.I.; Herluf V. Olsen, Lowell General Hospital, Lowell, Mass.; Harold W. Peterson, Mount Sinai Hospital, Minneapolis; Nick Rajacich, Johns Hopkins Hospital, Baltimore; Foster L. Riggs, St. Luke's Hospital, Milwaukee; Kenneth A. Rindflesh, Denver General Hospital, Denver; Elmer R. Salovich, St. Barnabas Hospital, Minneapolis; Boyd A. Sanderson, Charles T. Miller Hospital, St. Paul; Martin Saren, Grasslands Hospital, Valhalla, N.Y.; Dr. Miguel Solar, Hillsdale Community Health Center, Hillsdale, Mich.; Eugene L. Staples, University of Minnesota Hospitals, Minneapolis; James C. Talley, Norton Memorial Infirmary, Louisville, Ky.; Joel H. Walker, Syracuse Memorial Hospital, Syracuse, N.Y.; Robert J. Wilkins, Good Samaritan Hospital, Portland, Ore.; Lawrence L. Wilson, Baylor Hospital, Dallas, Tex., and Donald E. Wood, Swedish Hospital, Minneapolis.

Dr. Bradley Announces Residency Appointments

ST. LOUIS.—Administrative residency appointments for members of the graduating class in the department of hospital administration at Washington University here have been announced last month by Dr. Frank Bradley, course director.

The residency appointments are as follows: Roderic M. Bell, Baylor Hospital, Dallas, Tex.; Wilbur M. Birthelmer, University Hospitals, State University of Iowa; James A. Canedy, Bishop Clarkson Memorial Hospital, Omaha, Neb.; Augstin Diaz-Benabe, San Patricio's Hospital, San Juan, P.R.; Eugene C. Edwards, St. Luke's Hospital, Denver.

Dora Belle Ford, Missouri Pacific Hospital, St. Louis; Charles M. Goff, Miami Valley Hospital, Dayton, Ohio; Dorothy D. Hagedorn, St. Louis County Hospital, St. Louis; Roland E. Lea, St. Louis County Hospital, St. Louis; Frank J. Schwermin, Methodist Hospital, Houston, Tex.

Others were: Warren W. Simonds, Barnes Hospital, St. Louis; George T. Stafford Jr., Methodist Hospital, Indianapolis; Leonard K. Thompson, Watts Hospital, Durham, N.C., and Neil C. Wortley, Burge Hospital, Springfield, Mo.

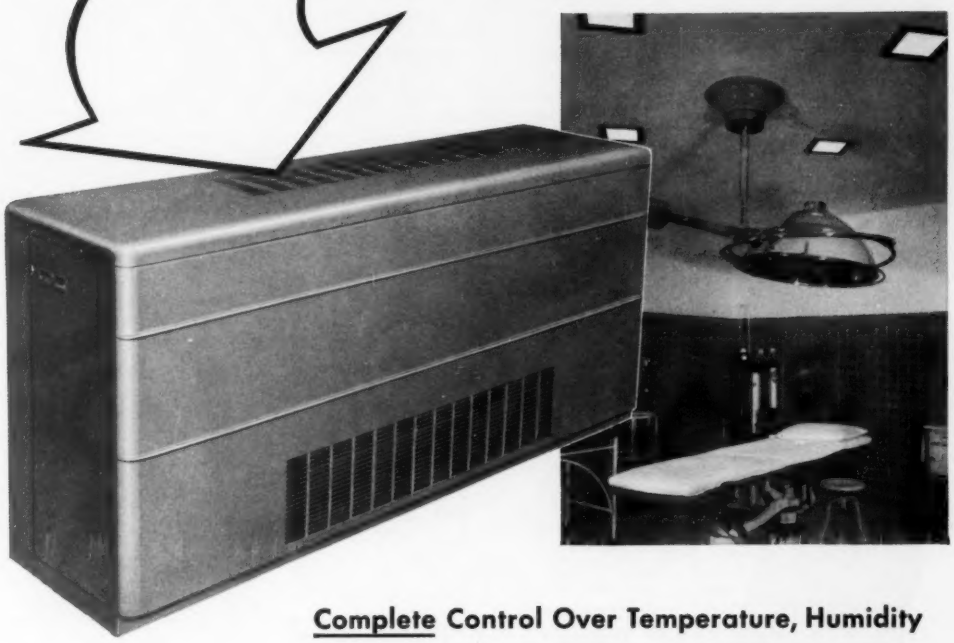
Public Health Service Issues Finance Manual

WASHINGTON, D.C.—A manual on hospital finance has been released by the Public Health Service Division of Medical and Hospital Resources, it was announced here last month. Entitled "Adequate Financial Support for Hospital Maintenance and Operation," the manual is planned to help sponsors of new hospitals built under the Hill-Burton program, it was explained, but it also contains material on budgeting, accounting and financing applicable to all hospitals.

The manual has been distributed to regional Public Health Service medical directors and to state health departments and other agencies administering hospital construction programs under the Hill-Burton Act, the division announced.

ANOTHER TRANE "FIRST"

OPERATING ROOM AIR CONDITIONER



Complete Control Over Temperature, Humidity

Here's a brand new air conditioner that can bring just-right temperatures and exact humidities into the operating room with complete safety—the new Trane Hospital Operating Room Air Conditioner.

It brings in and conditions outside air for the operating room. It filters the air. It adds moisture or wrings it out of the air to provide correct humidity. It heats or cools the air to the perfect operating room temperature. Then it sends that perfectly-tempered air through the room evenly and quietly.

Created with safety in mind, the unit has spark-proof fans and an explosion-proof motor. All electrical circuits, wiring, switches and fan belt are selected with an eye to safe and trouble-free service. The unit is designed for use in operating rooms regardless of the anesthetic used.

Each Operating Room Air Conditioner has its own control system, so each room has just the conditions it needs just when it needs them. When cooling isn't necessary, the unit can be an efficient source of heating. It will send out warmth in convection currents, without fan or motor.

Trim and compact, the Operating Room Air Conditioner fits snugly under a window. The clean, attractive casing is fully insulated with fiberglass to assure quiet and efficient performance, and the removable front panel means quicker, easier maintenance. Four sizes of the unit, with capacities ranging from 1 to 5 tons of cooling, can meet the needs of virtually any operating room.

For air conditioning that is designed for, and perfectly suited to, operating room needs—see your architect or local Trane representative about the new Trane Hospital Operating Room Air Conditioning Unit.

THE TRANE COMPANY, LA CROSSE, WISCONSIN

Eastern Mfg. Division, Scranton, Pennsylvania
Trane Company of Canada, Ltd. . . . Toronto

OFFICES IN 80 U.S. AND 14 CANADIAN CITIES

TRANE

MANUFACTURING ENGINEERS OF HEATING, VENTILATING AND AIR CONDITIONING EQUIPMENT

THE BOOK SHELF

ADMINISTRATIVE MEDICINE. *Edited by Haven Emerson, M.D., New York: Thomas Nelson & Sons,* 1951.

"Administrative Medicine" is written by qualified and noted authors. The range of information, from the organized care of the sick, through the administration and economics of medical care, public health administration, and performance of the Public Health Services, is organized and presented in an encyclopedic manner. More than 50 contributors have prepared as many chapters within these categories.

Dr. Emerson has gathered together in one volume the experiences and teachings of experts in public health methods and health administration. The organized care of the sick is presented under these headings: the general hospitals; rural hospitals; hospitals for acute communicable diseases; hospitals for tuberculosis; mental hospitals, including cottage colonies; hospitals for chronic (long-term) disease; convalescent homes; outpatient service; medical social service; Visiting Nurse Association—its development and present function; rehabilitation: the third phase of medicine; the administration of alcoholism rehabilitation programs.

In Part II, the federal health services are reviewed. In Part III, the public health services' administrative organization is reviewed, from the local health department, through the state, national and international levels. Part IV reviews the scope of various specialized public health services, such as vital statistics, communicable diseases, milk control, tuberculosis control, drug control, health education and accident prevention.

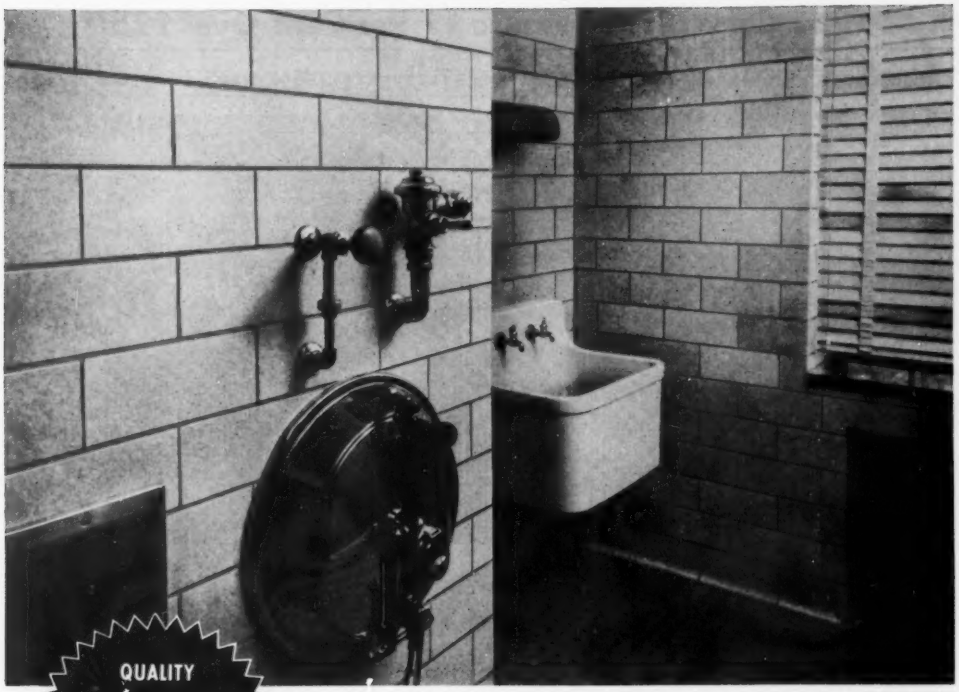
"Administrative Medicine" belongs in the library of every hospital administrator where it will serve as a reliable and complete source of information concerning administrative medicine. — ROBERT F. BROWN, M.D.

THE ADMINISTRATOR'S GUIDE ISSUE. *Part II of the June* 1951 *issue of Hospitals.*

This administrative guide book, formerly called the American Hospital Association Directory, has been improved this year to give more and better information for hospital executives. The first section on hospital plant summarizes in detail a five-year trend of the number and kind of hospitals and beds. Table IV in this section gives the number of admissions, occupancy, the average daily census of hospitals in various regional groupings in the country—good information for administrators to check with their own figures.

Anyone who is interested in the historical development of the American Hospital Association or who wishes to look up the names of officers, committee or council members through the years, will find the section on the association of great interest. Of particular interest and value is the last section of the book covering facts on the nursing service, dietary department, laundry, engineering and maintenance including safety in hospitals, housekeeping, pharmacy and purchasing.

In the purchasing section, the editors of this administrative guide issue have presented the condensed version of simplified practice recommendations and commercial standards. It is good to see this material in the administrative guide. The more people there are exposed to these standards, the faster they will be adopted and the better will be the purchasing job done by every one in the hospital field.—EVERETT W. JONES.



QUALITY AT ITS HIGHEST NATCO GLAZED VITRITILE

Showing use of Natco Ceramic Glazed Vitritile for interior walls and partitions in the Mental-Surgery Building of the Winnebago County Hospital, Winnebago, Wisconsin. Architects—Auler, Irion & Wertsch. Contractors—George A. Fuller Company.

In Winnebago County Hospital, Wisconsin, NATCO walls are sanitary, firesafe, lasting.

Everything in interior hospital walls and partitions is provided when built of Natco Ceramic Glazed Vitritile—outstanding endurance against hard usage, utmost in sanitation, vermin and germ proof, easily cleaned and kept clean—in pleasing color tones and attractive mottles.

Modular designed Natco Ceramic Glazed Vitritile coordinates fully with other building materials. There is little or no time-consuming cutting or fitting. First cost is last cost. There are no future plastering, painting or repair bills. The only maintenance required is simple washing with soap and water.

Send for a copy of Catalog SA-50 for additional information on Natco Ceramic Glazed Vitritile and other Natco Clay Products.

NATCO CLAY PRODUCTS SINCE 1889 — FTI — Member of Facing Tile Institute

NATIONAL FIREPROOFING CORPORATION

GENERAL OFFICES: 327 FIFTH AVENUE • PITTSBURGH 22, PA.

Branches: New York • Syracuse • Detroit • North Birmingham, Alabama
Chicago • Philadelphia • Boston • Toronto 1, Canada

"The Quality Line Since 1889"

Raggle Blocks Prevent Water Seepage 4" x 5⅓" x 12" Nom. Size

Speed-A-Backer Tile for Backing Brick Faced Walls 12" long Varying Heights

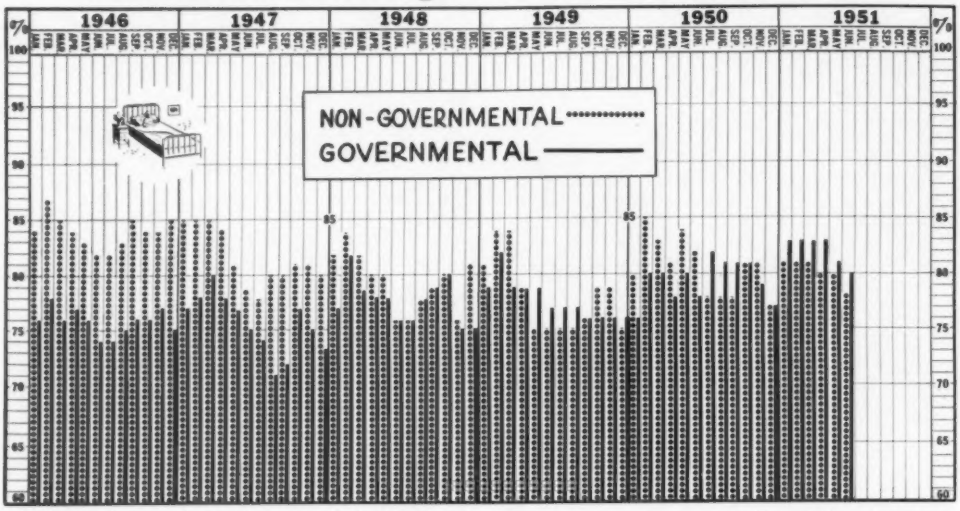
Ceramic, Clear Glazed Vitritile 5⅓" x 12" Nom. Face Size

Ceramic Glazed Vitritile 8" x 16" Nom. Face Size

Loadbearing Tile, Scored and Unscored, 12" x 12" Face Size in Standard Wall Thicknesses.

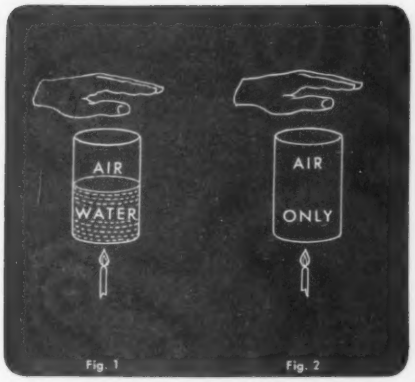
Buff Unglazed, Manganese Spot, Salt Glazed, Red Textured Dri-Speedwall Tile, 5⅓" x 12" Nom. Face Size

1951 Construction Figure 17 Per Cent Over 1950

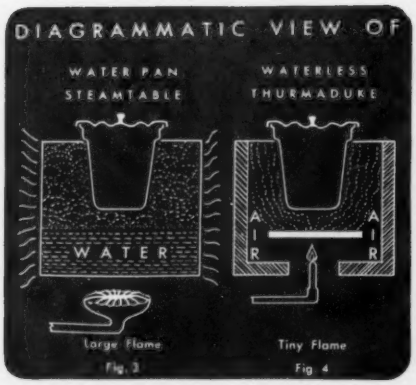


Following the normal seasonal course, hospital occupancies were slightly lower in June than in the previous months; governmental hospitals reporting to the Occupancy Chart were 80.1 per cent occupied, while nongovernmental hospitals showed only 77.6 per cent occupancy—lowest point of the current year.

Hospital construction reported for the month ending July 16 totaled $46,049,739—approximately the same as the figure reported for the corresponding period a year ago. At $454,096,209, the total for the year to date is 17 per cent higher than at this time last year. In the latest period this year, there were 10 new hospitals costing $18,018,000, and 23 additions costing $18,940,111.



Place a can half filled with water over a small flame. Do the same with an empty can. Notice how much more quickly the empty can heats up.



It takes much more heat to warm water than air. That's why the burners in a waterpan steam table are much larger than the tiny jets in THURMADUKE.

here's how you can prove

THURMADUKE *saves up to 70%*

MANY SIZES AND MODELS AVAILABLE
BOTH GAS AND ELECTRIC

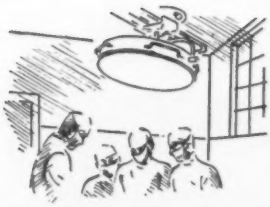
See your THURMADUKE Dealer or write for Catalog MH-8

The simple experiment above shows why *waterless* THURMADUKE uses so little gas. Numerous case records from THURMADUKE owners are further proof of this fact.

The THURMADUKE waterless principle offers many other advantages, too: *fast* heat – because no time is wasted heating gallons of water. *Controlled* heat – in each section. This permits you to keep each food at exactly the proper temperature to insure peak flavor, appearance and minimum shrinkage.

Add to these outstanding features, the beauty of THURMADUKE design, the superior construction and insulation, and you'll want a THURMADUKE, yourself.

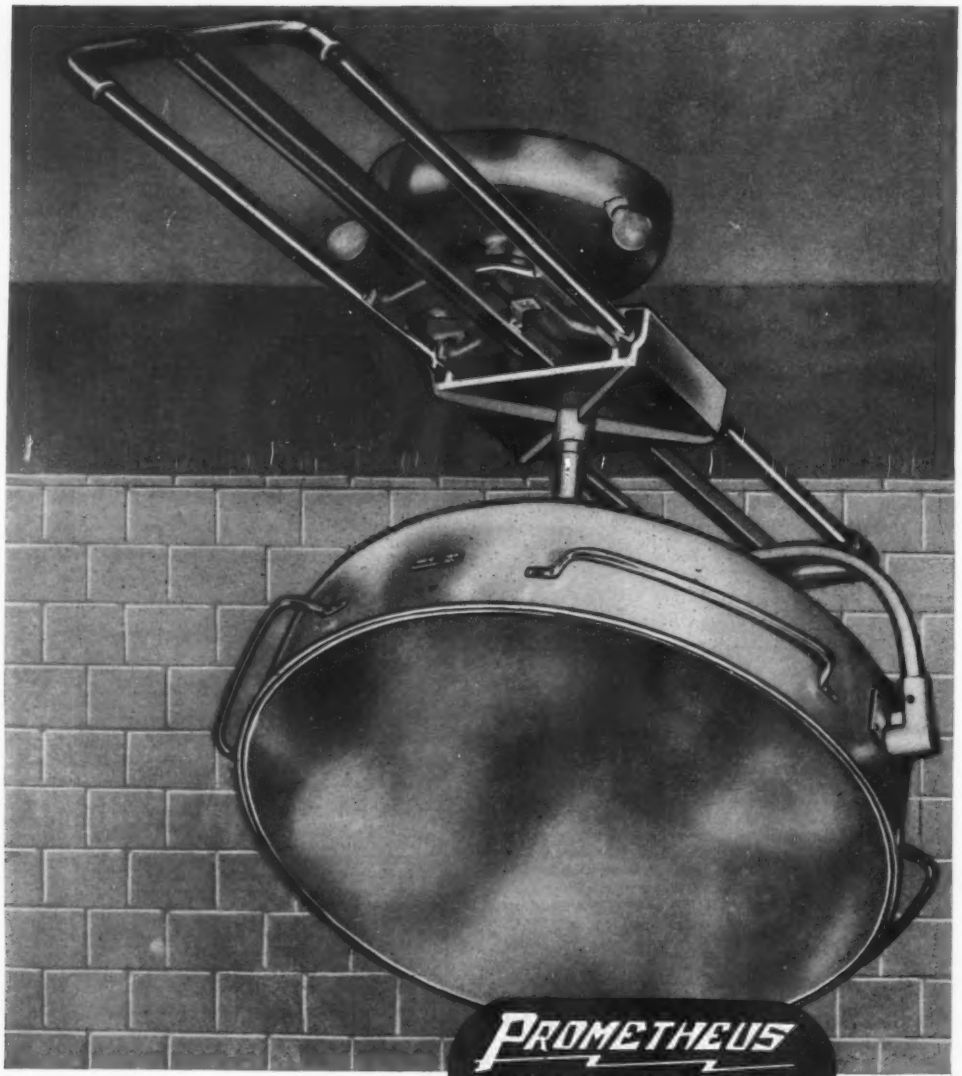
DUKE MANUFACTURING COMPANY • ST. LOUIS 6, MISSOURI



A new major Operating Light that eliminates "third rail" hazard!

This is the *only* major Operating Light that eliminates the "spark" hazard . . . a constant source of danger to both patients and personnel. An exclusive Prometheus feature puts an end to this problem. This light assures adequate lighting at the bottom of the incision.

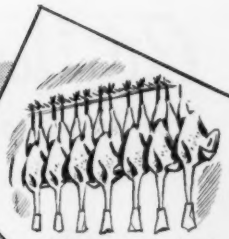
Rotary track mounted, there is never any need to move operating table to bring the light into proper position for the operation, whether it be an appendectomy, mastectomy, cholecystectomy, etc. Special scientific filters provide heatless, shadow-free, color-corrected light.



PROMETHEUS
ELECTRIC CORPORATION
401 W. 13th St., New York 14

Write for catalog of Prometheus Operating Lights, Sterilizers, Food Conveyors and other hospital equipment.

Everything points to Turkey!



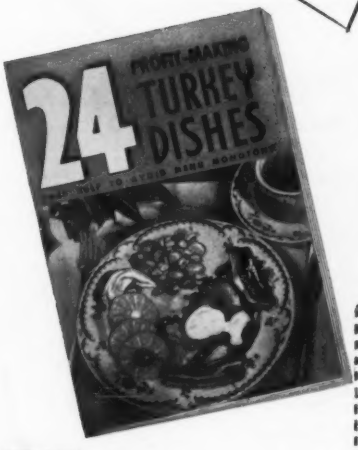
Adequate supply of high quality turkeys

Economy of serving turkey meat

Uncertain red meat supplies and prices

Greater demand for turkey on the menu

New methods of cooking turkey — braise, broil, fry or roast it



FREE REPRINT TELLS THE STORY

FREE BOOKLET SHOWS YOU HOW

. . . and that's why authorities are predicting for this year the greatest consumption of turkey meat in the nation's history.

It will pay to buy early to assure your institution of an adequate supply of America's all around meat of the year . . . TURKEY!

NATIONAL TURKEY FEDERATION

MT. MORRIS - ILLINOIS

NATIONAL TURKEY FEDERATION
Mt. Morris, Illinois

☐ Please send me a free reprint "Turkey on the Hospital Menu."

☐ Please send me free booklet "24 Profit-Making Turkey Dishes."

Name of Institution.....

City and State.....

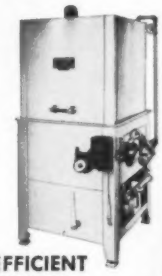
By.....

Cut Your Kitchen Costs

with up-to-date TOLEDO machines

NEW SLICER WITH ESTIMATOR

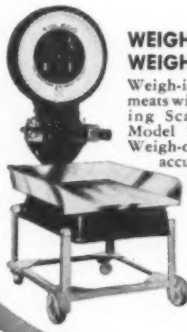
The Toledo Quick-Weigh Estimator—saves time, saves steps. Portions can be estimated right on the slicer. Illuminated platter . . . greatest ease of operation and cleaning . . . full choice of slice thicknesses up to ¾".



FAST, EFFICIENT DISHWASHING

Toledo *Door-Type* Dishwashers, with 3-Way Door, opens front and both sides . . . Zip-Lok makes it easy to remove spray tubes for cleaning, without tools. *Conveyor-Type* in full range of sizes and capacities.

1901-1951 50th ANNIVERSARY



WEIGH IT IN WEIGH IT OUT

Weigh-in all produce and meats with Toledo Receiving Scales . . . Portable Model 1800 shown here. Weigh-out portions quickly, accurately with Toledo Speedweigh over-and-under scales.

AND THESE TOLEDOS, TOO!


Choppers


Steak Machines


Saws


Peelers

TODAY IT'S

TOLEDO

ALL THE WAY!

SEND FOR BULLETINS

Check your needs . . . send for latest bulletins on these modern Toledo Kitchen Machines for your requirements today—

- ☐ Peelers for potatoes and vegetables
- ☐ Door-Type Dishwashing Machines
- ☐ Conveyor Dishwashing Machines
- ☐ Slicer with Quick-Weigh Estimator
- ☐ "Gravity-Feed" Choppers
- ☐ Power Meat Saws
- ☐ Steak Machines
- ☐ Speedweigh Portion Scales
- ☐ Receiving Scales
- ☐ Ingredient Scales

Write to . . . Toledo Scale Company, Toledo 1, Ohio

3 ways to STOP cold coffee complaints

COLD COFFEE means irate customers or patients . . . sends good money down the drain.

But with STANLEY Coffee Servers hot beverages stay appetizingly hot to the last drop. By test genuine STANLEYS keep liquids 20° hotter after 2 hours than do ordinary pots.

STANLEYS are finished in nickel, chromium or silver, never crack or chip—actually pay for themselves in reduced replacements. Write for complete information today.

Genuine STANLEY
UNBREAKABLE THERMAL CONTAINERS

STANLEY INSULATING DIVISION
Landers, Frary & Clark • New Britain, Conn.

1

CHARTER PATTERN
10-oz. and 20-oz. capacity

2

FRED HARVEY PATTERN
12-oz. capacity

3

WALDORF-ASTORIA PATTERN
10-oz. and 20-oz. capacity
All models etched with crest or name at slight additional cost.

Notable PROGRESS IN A SPECIAL FIELD

Today the list of Ideal Firsts is the record of progress in hospital equipment for feeding operations and other practical services.

Ideal brings to dietician and nurse advanced mechanical aids developed and manufactured with the same precision, quality and care that is given to the equipment used in laboratory, surgery and departments for diagnosis and treatment.

Every Ideal First marks the advent of valuable advantages not previously available to patient or staff. Ideal Food Conveyors give to the patient the maximum benefits of nutritional therapy, and to the staff complete and accurate control over diets together with gratifying economies in time and labor. Ideal Hot Pack Heater delivers perfect hot packs at bed side with unprecedented ease and speed.

More Ideal Firsts are on the drafting board and in the pilot stage. You will be keenly interested in Ideal announcements to be made in the near future.

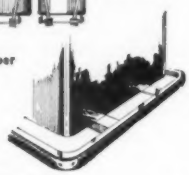
HIA HOSPITAL INDUSTRIES ASSOCIATION

THE SWARTZBAUGH MANUFACTURING COMPANY
TOLEDO 4, OHIO

IDEAL FIRSTS

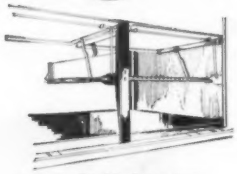
The first hospital food conveyor ever built was an Ideal. Ideal also developed and built the first electric hospital food conveyor. Other notable Ideal Firsts are listed below. Imitations, of which there are many, approach the original only superficially.

Bridge-type top construction.

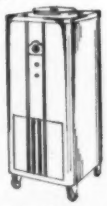


Interchangeable bumper (no screws, etc.)

Special diet trays.



Double lever overhead doors, later improved to allow shifting of material from one compartment to the other.



An automatic Hot Pack Heater.

Ideal
FOOD CONVEYOR SYSTEMS
Found in Foremost Hospitals

classified advertising

TERMS: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR—Assistant; age 31; B.S., Education; M.A., Psychology; M.S., Hospital Administration; experience in teaching and personnel psychology; year's administrative residency. MW 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Medical; 36; Master, Hospital Administration; residency in large teaching hospital; 7 years' administrator medium and small hospitals; seeks position abroad. MW 47, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Prefer 100-bed hospital or sanatorium; experience includes 8 years as chief dietitian; capable all phases purchasing, special diets, personnel, etc.; location is not important; 4 years' college. MW 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PURCHASING AGENT—Seeking change with possibilities for further advancement in this field; references exchanged in strict confidence. MW 39, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SECRETARY—Medical; private; with five years' hospital experience, desires position in United States; top references. MW 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Medical; five years, director, voluntary general hospital, 500 beds; six years' director, teaching hospital and on faculty university school of hospital administration; FACHA.

ADMINISTRATOR—Lay; MBA, Hospital Administration; year's administrative internship and three years' administrative assistant, large teaching hospital.

ADMINISTRATOR—Lay; Degree in Business Administration, Harvard; eight years' administrative experience, public institutions; seven years, director, voluntary general hospital, 300 beds; FACHA.

ADMINISTRATOR—B.S., Nursing Education; M.A., Hospital Administration; eight years' experience in teaching and as of director of nurses before specializing.

ANESTHESIOLOGIST—Diplomate; five years, director, anesthesiology, 300-bed hospital; seven years, director, departments two hospitals, private practice.

DIRECTOR—B.S., Institutional Economics; M.A., Management; 12 years, director, dining hall and residences, instructor, institutional management, large university.

MEDICAL BUREAU—*Continued*

NEUROPATHOLOGIST—Three-year residency, neurology, psychiatry; now completing training in neuropathology; Board eligible.

PATHOLOGIST—Diplomate, Fellow, College of American Pathologists, M.S., Pathology; five years, director of laboratories, group of small hospitals; on faculty, university medical school.

RADIOLOGIST—Diplomate; five years' training, university center; now associate radiologist, teaching hospital and associate professor, radiology, medical school.

For further information, please write Burneice Larson, Medical Bureau, Palmolive Building, Chicago.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—FACHA; 15 years' successful experience, 150-350 bed hospitals; last position reorganizational and building program; prefers east.

ASSISTANT ADMINISTRATOR—B.S. Degree; M.H.A. Degree, 1948; administrative resident, and assistant; 3 years; large hospital preferred.

SUPERINTENDENT — R.N.; FACHA; 14 years' experience; 75-100 bed hospitals; excellent business manager as well; mid-west appointment.

HOUSEKEEPER—12 years, university hospital, mid-west; 3 years' Connecticut hospital, 300 beds.

OUR 55th YEAR
WOODWARD
Medical Personnel Bureau
FORMERLY AZNOE'S
3rd floor • 185 N. WABASH AVE.
CHICAGO • 1
• ANN WOODWARD • *Director*

ADMINISTRATOR—Male; R.N.; B.A.; M.A. Hospital Administration; 2 years, hospital administrative residency; several years, office manager, 200-bed hospital; 5 years, administrator, 100-bed hospital; member, ACHA; seeks hospitals 150-300 beds; assistantship, larger hospitals; available 2 months.

ADMINISTRATOR—6 years, manager, finance company; 2 years, credit manager, 3 years, administrator, 100-bed hospital; 4 years, administrator, 300-bed hospital; 4 years, administrator, 200-bed hospital; seeks warm climate, preferably dry, due to member of family health requirement; age 44; member ACHA; available one month.

(Continued on page 188)

WOODWARD—*Continued*

ADMINISTRATOR—Female; R.N.; 3 years, hospital administrative residency; member, ACHA; 6 years, administrator, 100-bed hospital; 8 years, administrator, 150-bed hospital; age 45; available 30 days.

ADMINISTRATOR—36; B.A., Hospital Administration, Cornell; 4 years, chief, cost division, large steel company; 3 years, administrator, 100-bed hospital; seeks larger hospital with building program; available 2 months.

ADMINISTRATOR—29; A.B., State University; M.A., Hospital Administration; 1 year, administrative residency, 3 years, assistant administrator, 250-bed university hospital; seeks directorship, hospitals 100 beds and over; any locality; available 30 days.

RADIOLOGIST — 39; Diplomate, American Board, Radiology, Certified in both; 8 years, medical officer, radiology; USNMC; 1 year, chief, 1000-bed veterans' administration hospital; 1 year, director of department, 200-bed eastern hospital; interested only in California, Nevada, Colorado or Arizona; hospital, group of small hospitals, group-clinic or association; available immediately.

RADIOLOGIST—Passed Therapeutic Boards; eligible for Diagnostic Boards; well qualified in oncology; several years' private practice, radiology; past 10 years, director of department, 300-bed hospital; also, consultant, several large hospitals; available immediately.

PATHOLOGIST—31; Certified in Pathologic Anatomy; eligible for certification in clinical pathology; 3 years, instructor, 1 year, assistant professor, university school of medicine; also 1 year, coroner's pathologist, large southern city; seeks directorship of hospital or group.

PATHOLOGIST — 33; Certified, Pathologic Anatomy; eligible certification, clinical pathology; 3 years, residency and associate pathologist, 300-bed teaching hospital; 3 years, director department, 250-bed general hospital; seeks association, hospital or group clinic.

ANESTHESIOLOGIST — Diplomate, American Board of Anesthesiology; 42; 3 years, director, anesthesia, 300-bed hospital; 4 years, anesthesia, USNMC, Lieutenant Commander; 2 years, director, anesthesia, 300-bed hospital; since 1948, attending anesthesiologist, several large hospitals; seeks director, department, large hospital or private anesthetist with group; available 60 days.

ANESTHESIOLOGIST—35; B.S., M.D., Indiana Medical; has completed Anesthesiology Board examination; seeks private fee anesthesia with group or hospital; licensed Indiana, California; immediately available.

DIRECTOR OF NURSES—38; A.B., M.A., Nursing Education; 3 years, head nurse and medical and surgical supervisor, 350-bed general hospital; 3 years, medical supervisor and assistant director nursing service, 800-bed general hospital; since 1949, director of nursing, 200-bed general hospital; prefers east or warm climate; $5500 without or equivalent with maintenance; immediately available.

classified advertising

POSITIONS WANTED

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPER—4 years, director of housekeeping, 600-bed university hospital; 4 years, executive housekeeper, 400-bed hospital; highly qualified to organize, develope department for new building; immediately available.

REGISTERED RECORD LIBRARIAN — 5 years, history record and postmortem records, Mayo Clinic; 4 years, assistant record librarian, and 5 years, chief, record librarian, 200-bed general hospital; seeks large hospital only; $375; Member, AAMRL; age 47; immediately available.

NURSE ANESTHETIST—R.N.A., 27; 5 years, R.N., delivery room supervisor and anesthetist; 300-bed general hospital; interested western states; Member, A.A.N.A.; $400; immediately available.

PHARMACIST—31; male; B.S., Pharmacy, minor in chemistry, state university; 4 years, assistant pharmacist, state university hospital; Member, A.P.A.; seeks hospital or group; $450; immediately available.

BACTERIOLOGIST—Male; 31; B.S., Bacteriology, minor in chemistry, state university; 5 years, United States Army; 2 years, special chemist; 3 years, bacteriologist, large industrial company; $350; available immediately.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

ADMINISTRATOR—Lay; 100-bed hospital, or larger; previous experience, assistant administrator 500-bed general hospital; personnel and public relations director, hospital and industry; man of exceptional ability, age 32; top recommendation; available about January 1st; any location.

POSITIONS OPEN

ADMINISTRATOR—Assistant; lay or medical; for progressive eastern Canadian hospital of more than 200 beds with large expansion program now under way; excellent opportunity for qualified person who has had administrative experience in the fields of personnel management, purchasing, public relations, as well as in other departments. MO 26, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; 87-bed general hospital; ACS approved; one full time nurse anesthetist already on duty; salary open; maintenance, vacation with pay, sick leave furnished. Apply, Director, Harford Memorial Hospital, Havre de Grace, Maryland.

ANESTHETIST—Nurse; 500-bed teaching hospital; starting salary, $4323 per year with stated periodic increases; 16 days paid sick leave, 12 holidays and 12 days vacation per year. Apply, Harold F. Chase, M.D., Director of Anesthesiology, University of Virginia Hospital, Charlottesville, Virginia.

ANESTHETIST—Nurse; for general hospital; must be able to administer latest types of anesthetic agents; salary $290 to $325 per month plus full maintenance; annual vacation and sick leave granted; retirement benefits available if desired. Apply, Superintendent, Robinson Memorial Hospital, Ravenna, Ohio.

ANESTHETIST—Nurse; new modernly equipped 44-bed hospital; attractive salary, good living conditions. Lauderdale County Hospital, Ripley, Tennessee.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse; 187-bed general hospital; 15 miles north of Pittsburgh, Pennsylvania; salary, $275-$300 plus meals and laundry; 50-hour week policy; 28 days vacation; 10 days sick leave; 5 holidays or equivalent. Apply, Superintendent, Sewickley Valley Hospital, Sewickley, Pennsylvania.

ANESTHETIST—Nurse; 141 adult beds for white women only; also to administer intravenous fluids; full maintenance; state salary required. Apply, Director, Women's Hospital, Baltimore 17, Maryland.

ANESTHETIST—Nurse; for most modern hospital in southeastern Illinois; $300 per month plus maintenance. Apply, Administrator, Wabash General Hospital, Mt. Carmel, Illinois.

ANESTHETIST—Nurse; starting salary $300; maternity and general service; sick leave and paid vacation, also six national holidays paid; 80-bed, fully approved hospital; call rotated with 3 nurse anesthetists under medical anesthetist. MO 34, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETISTS—Immediate openings for two qualified nurse anesthetists in fully approved 210-bed hospital; medical supervision. Write Daniel C. Moore, M.D., Director of Anesthesiology, Virginia Mason Hospital, Seattle 1, Washington.

ANESTHETISTS—Nurse; two; have three anesthetists now; call hours are arranged among them; no obstetrical calls between 11 P.M. and 6 A.M.; salary open. Apply, Hibbing General Hospital, Hibbing, Minnesota.

ANESTHETISTS—Nurse; two; needed for the Lying-In Department of the New York Hospital; experienced in obstetrics and gynecology anesthesia; attractive salary and good personnel policies; vacation, one month; 40-hour week; quarters available if desired. Apply, Chief Anesthetist, Lying-In Department, M-822, New York Hospital, New York 21, New York.

ANESTHETISTS—Nurse; two needed; modern well equipped 170-bed hospital; fully accredited, active member AHA; attractive salary, maintenance optional; vacation, sick leave. Apply Administrator, Theda Clark Memorial Hospital, Neenah, Wisconsin.

DIETITIAN—Administrative, ADA member; 125-bed general hospital. Frederick Memorial Hospital, Frederick, Maryland.

DIETITIAN—Assistant; generous salary open depending on qualifications; applications desired from members of ADA or other well qualified persons. Apply to Superintendent, William Roche Memorial Hospital, 945 South Detroit Avenue, Toledo 9, Ohio.

DIETITIAN—Assistant; 308-bed hospital; salary open. Apply, A. Finch, Mercer Hospital, Trenton, New Jersey.

DIETITIAN—Chief; for 270-bed teaching hospital located conveniently near Chicago's loop on the beautiful lake front, Northwestern University campus; responsibilities include supervision, menu planning, purchasing, food preparation, therapeutics, and food service; excellent salary, high food standards, maximum opportunity for good person to exercise initiative; ADA member. Write or apply Personnel Department, Passavant Hospital, 303 East Superior, Chicago 11, Illinois.

(Continued on page 190)

DIETITIAN—Experienced; for administrative assistant to chief dietitian. Apply, Personnel Office, Touro Infirmary, New Orleans, Louisiana.

DIETITIAN—For 95-bed approved hospital; experienced; beginning salary, $265; maintenance available; 41½-hour week; travel expenses refunded at end of 18 months of service. Apply, G. N. Wilcox Memorial Hospital, Lihue, Kauai, Territory Hawaii.

DIETITIAN—Qualified and experienced for 162-bed general hospital with school of nursing; state age, qualifications, religion and salary expected. Apply, Superintendent of Nurses, General Hospital, Glace Bay, Nova Scotia.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIANS—Baltimore City Hospitals, Baltimore, Maryland; invites inquiries about positions for dietitians, which are now open; dietary department is rapidly expanding and currently serves 6000 meals per day; good salaries and desirable personnel practices.

DIRECTOR—Educational; for 377-bed hospital with accredited school of nursing; basic sciences taught at Norfolk Division, College of William and Mary; effective student government; Degree in Nursing Education and teaching experience essential; excellent personnel policies; salary commensurate with preparation; complete maintenance available; position open June 1st; must be filled by August 1st. Apply Director of Nurses, Norfolk General Hospital, Norfolk, Virginia.

DIRECTOR—Educational; 275-bed hospital with state approved school; student body 110; well equipped hospital located in central Ohio; master's degree preferred; experience required; salary open. MO 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Assistant; B.S. Degree; experience of 1 to 2 years in the field; Pennsylvania registration; salary, $2700 to $3000 a year; liberal personnel policies; 300-bed hospital. Apply to the Director of Nurses, Lancaster General Hospital, Lancaster, Pennsylvania.

DIRECTOR OF NURSES—275-bed general hospital; accredited school of one hundred students; master's degree preferred; nursing administration experience necessary; salary open; position available July 15th. Apply Administrator, Lima Memorial Hospital, Lima, Ohio.

DIRECTOR OF NURSING—125-bed general hospital with school of 50 student nurses; new construction program underway; degree required; salary open; full maintenance in attractive apartment in nurse's residence; short distance to New York City and Albany, New York. For further information write Administrator, Columbia Memorial Hospital, Hudson, New York.

DIRECTOR OF NURSING AND NURSING SCHOOL—For 150-bed general hospital; enrollment, 65 students; affiliated with Northern Michigan College of Education; salary open. Apply, Audrey Shade, R. N., Superintendent, St. Luke's Hospital, Marquette, Michigan.

the case of the AMAZED truckdriver...

Ten times he heaped his disposal truck with cartons full of medical records – the contents of *two entire rooms.*

Then they showed him a small cabinet . . . *and told him that in it were copies of every single record he had just hauled away.*

Even *you* would be amazed at the tremendous space savings possible through microfilming–more than 99%! Here at Northwest Texas Hospital is another instance of where it has relieved an overcrowded condition easily and economically.

Remington Rand microfilming brings other important benefits, too. The time required to locate records is greatly reduced. Misfiling and tampering is prevented. Full size black and white copies can be made quickly. Records receive better protection – when properly stored microfilm is more durable than the finest grade of paper.

You, like Northwest Texas, can accomplish all of this *without lifting a finger.* Simply turn over your bulky original records to Remington Rand Microfilm Contract Service. In return you will receive small, compact rolls of film all properly authenticated and thoroughly indexed for fast reference. You do not have to buy microfilming equipment, interrupt your routine, or use your own personnel.

Find out more about this fast, simple way of having your records put on microfilm. Ask for the free illustrated booklet F-249. Or, if you wish to do your own microfilming, ask about the automatic Film-a-record machine. Just write to Room 1297 Management Controls Reference Library, 315 Fourth Ave., N. Y. 10.

3,000,000 records in one small cabinet

Remington Rand

classified advertising

POSITIONS OPEN

DIRECTOR OF NURSING AND NURSING SCHOOL—200-bed general hospital with approved school of seventy students; well equipped; located in Chicago; Master's Degree preferred, experience necessary; salary open, available July 1, 1951. MO 23, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING SERVICE—Assistant; for 138-bed, 18 bassinet general hospital; student body, 81; located in the beautiful hills of western Pennsylvania; gross annual salary, $3300; 45½-hour week; one months' vacation with pay per year; 13 holidays; qualifications, B.S. Degree in Nursing, some experience; registration in Pennsylvania or eligible. Apply, Director, Philipsburg State Hospital, Philipsburg, Pennsylvania.

DIRECTOR OF SCHOOL OF NURSING—Associate; for 325-bed general hospital with approved school of nursing; student body 140; well equipped hospital located in a fine residential section of an Ohio city, near Detroit; Master's Degree preferred; experience necessary; position available July 1, 1951. MO 21, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Assistant clinical; for 192-bed general hospital; student enrollment 75; medical surgical nursing, qualified to teach pharmacology; salary open; position available now. MO 29, The Modern Hospital, 919 N. Michigan, Chicago 11.

INSTRUCTOR—Clinical; for 150-bed hospital with school of nursing; 44-hour week; 4 weeks' vacation; 2 weeks' sick allowance; a friendly city, near local college; salary open; position now open. Apply, Director of Nursing, Elliot Community Hospital, Keene, New Hampshire.

INSTRUCTOR—Clinical; 300-bed hospital; average student body of 150; fully approved school of nursing; experienced person preferred, but will consider a recent graduate; starting salary open; good personnel policies. Apply, Director of Nurses, Lancaster General Hospital, Lancaster, Pennsylvania.

INSTRUCTOR—Nursing clinical; for 390-bed hospital with school of 200 students; to work with another clinical instructor; separate office in hospital; 1 month vacation, sick leave, pension plan; salary in accordance with Saskatchewan Registered Nurses' Association recommendations. Apply, Director of Nursing, City Hospital, Saskatoon, Saskatchewan.

INSTRUCTOR—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

(Continued on page 192)

INSTRUCTOR—Surgical clinical; 600-bed general hospital; 200 students; operating and recovery room not included in this assignment. For details contact, Director of Nursing Service, Jackson Memorial Hospital, Miami 36, Florida.

INSTRUCTORS—Clinical and Science; for 400-bed voluntary hospital with school of nursing fully approved; experienced person preferred, will consider recent graduate; starting salary open; excellent maintenance facilities if desired. Apply Personnel Director, Christ Hospital, Cincinnati 19, Ohio.

INSTRUCTORS—Clinical; 2; medical and surgical for 325-bed general hospital; degree and experience preferred. Apply, Director, School of Nursing, The Toledo Hospital, Toledo, Ohio.

INSTRUCTORS—Nursing arts and science; by August 1; new hospital under construction; state qualifications and salary expected. Apply, Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

LIBRARIAN—Medical record; take charge 200-bed general hospital; $250 monthly; cross-indexing. Apply, Superintendent, Mt. St. Mary's Hospital, Niagara Falls, New York.

LIBRARIAN—Medical record; 300-bed general hospital in central Pennsylvania; salary open. Apply, The Williamsport Hospital, Williamsport, Pennsylvania.

MONARCH offers a complete dressing line that is Definitely FINER!

A Salad Dressing For Every Need

- **MONARCH Mayonnaise** has a combined egg and oil content of 87%.
- **MONARCH Salad Dressing**—minimum oil content of 35%.
- **MONARCH Thousand Island Dressing**—one of the most popular in this most popular line.
- **MONARCH Combination Dressing**—a truly different combination of mayonnaise and Russian that is tantalizingly different for fruits and for vegetable salads.
- **MONARCH Roquefort Cheese Dressing**—so perfectly homogenized that it retains its lusty Roquefort taste to the last delicious spoonful.
- **MONARCH Russian Dressing**—truly exotic and taste thrilling!
- **MONARCH French Dressing**—perfectly emulsified—will not separate.
- **MONARCH Dill Dressing**—a different dietary delight, perfect for salads, fish and meat . . . has that real dill flavor.

Summer months are salad months. Use MONARCH dressings and insure your Summer Salad Success. Packed in Institutional and smaller sizes.

classified advertising

POSITIONS OPEN

LIBRARIAN—Medical record; 250-bed hospital; city 50,000, 75 miles from New York; salary $4200 per annum. Apply, Administrator, Vassar Brothers Hospital, Poughkeepsie, New York.

MISCELLANEOUS—Superintendent of nurses; also Public health nurse, four Floor supervisory nurses for Arizona; Nurse administrator, two General duty nurses, Anesthetist and Community hospital nurse for Alaska; graduate, single nurses with college degree preferred; candidates must be in good health and willing to participate in religious program. Write, Presbyterian Board of National Missions, Room 703, 156 Fifth Avenue, New York 10, New York.

MISCELLANEOUS — Anesthetists; 2; Pediatric supervisor; prefer post-graduate, one capable of teaching students; Head nurse; medical and surgical floor; Operating room nurses; 2; Instructor in medical and surgical nursing; good working policies; 181-bed private hospital; 44-hour week; vacation and sick leave after one year of service. Apply to Director of Nurses, Elizabeth Buxton Hospital, Newport News, Virginia.

MISCELLANEOUS—Well qualified Director of nurses for 250-bed North Carolina Hospital; also Dietitian, ADA, for same institution. Memorial Mission Hospital, Asheville, North Carolina.

MISCELLANEOUS—Surgical clinical instructor; immediately; salary open; also General duty nurses for 250-400-bed hospital; salary $205 plus two meals and the laundry of four uniforms; $15 differential for evening and night duty. MO 25, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—General duty; 19-bed hospital soon expanding to 50 beds; college town of 6000, in resort area; salary open; liberal personnel policies; retirement plan; choice of rotating shifts or straight 3-11 or 11-7. Apply, R. Houfek, Administrator, Ripon Municipal Hospital, Ripon, Wisconsin.

NURSE—Instrument; $300 per month plus full maintenance; 70-bed hospital; western Pennsylvania college town. MO 30, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Operating room; for 120-bed modern tuberculosis hospital; starting salary $200 per month, plus full maintenance; 44-hour week; day duty only; 2 weeks' vacation and 2 weeks' sick leave yearly; group insurance and retirement plan. Clark County Tuberculosis Sanatorium, Springfield, Ohio.

NURSES—General duty; come to Miami, the south's vacation land; 600-bed, rapidly expanding general hospital; beginning salary $219; excellent opportunity for advancement; 3 weeks vacation and 7 holidays annually; semi-private rooms for three months at nominal fee. Apply Director of Nursing service, Jackson Memorial Hospital, Miami 36, Florida.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-operative Hospital, Lockney, Texas.

NURSE—Staff; small hospital with doctor's office at Grand Canyon National Park; experience in x-ray and laboratory preferable. Apply, Dr. Leo Schnur, Director, Grand Canyon Hospital.

NURSES—General duty; for small, 35-bed community hospital with cheerful and friendly atmosphere; fully accredited active member of AHA; salary $165 plus full maintenance and uniform laundry; increases at 6 month intervals to $180; paid vacation and sick leave. Apply, Superintendent, Edgerton Memorial Hospital, Edgerton, Wisconsin.

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—General duty; graduate; 57-bed general hospital; university town; private accommodations; new nurses home; pleasant mountain surroundings; state salary expected. Apply, Administrator, Emerald-Hodgson Hospital, Sewanee, Tennessee.

(Continued on page 194)

classified advertising

POSITIONS OPEN

NURSES—General staff: also head nurses and supervisors; general staff nurses starting salary $2820, maximum $3525; head nurses, $3240 to $4050; supervisors, $3420 to $4275; yearly increments; 44-hour week, time arranged to attend classes, otherwise rotating shift; 13 legal holidays; paid vacations, 30 days and sick leave 15 days, included with salary. Contact, Mrs. Eva Darley, Associate Director of Nursing Service, University Hospital, Baltimore 1, Maryland.

NURSES—General duty; licensed; for all shifts: 44-hour week day duty; 40 hours, evening and night duty; salary $2400 per year; liberal personnel policies; meets approved minimum employment standards of state nurses association. Apply, Director of Nurses, Christ Hospital, 176 Palisade Avenue, Jersey City, New Jersey.

NURSES—General duty; starting salary, $210 per month; to staff new 54-bed excellently equipped hospital; additional pay for evening and night duty; 44-hour week. Apply, Administrator, Wabash General Hospital, Mount Carmel, Illinois.

NURSES—General staff; 175-bed hospital, city 20,000; rotating service $210; night duty $220; $5 increase in 6 months. Apply, Director of Nursing Service, Good Samaritan Hospital, Vincennes, Indiana.

NURSES—General duty; for 300-bed hospital located 45 miles from New York City on Long Island Sound; salary $242.66 with annual increases for three years up to $268.66; 10 per cent bonuses for evenings, nights, week-ends and holidays; full maintenance available at minimum rates; 8-hour day; 40-hour week; paid vacations and health benefits. Apply, Mrs. Sylvia Mertin, Director of Nursing, Stamford Hospital, Stamford, Connecticut.

NURSES—Graduate; for general staff duty in 160-bed hospital; $225 monthly with $10 differential for evening or night shift. Apply, Mrs. Ruth Garland, R.N., Memorial Hospital of Natrona County, Casper, Wyoming.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $216 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 60.

NURSES—Graduate; full or part-time; for 150-bed general hospital with a modern new addition of 150 beds to be opened in the fall; located in the heart of the Montana Rockies, in state university town; personnel policies in accord with those requested by the Montana State Nurses' Association. For information write, Director of Nursing Service, St. Patrick Hospital, Missoula, Montana.

(Continued on page 196)

NURSES—Graduate; junior staff for delivery room, infant care and general duty; beginning salary $205 for 44-hours per week; increases after six months, one year and two years; $20 month differential for evening and night duty. Apply, Superintendent of Nurses, St. Louis Maternity Hospital, 630 South Kingshighway, St. Louis 10, Missouri.

NURSES—Graduate staff; for 44-hour week, day, evening or night shifts or rotating; for new 300-bed hospital which will be open in August 1951; applications being received for all departments; vacancies at the present time in 110-bed hospital for evening nurses. Write, Mildred B. Whittet, Assistant Director of Nursing, Methodist Hospital, Houston, Texas.

NURSES—Graduate registered; for general duty; days, $200; afternoon and nights, $225 with full maintenance. Apply, Safford Inn Hospital, Safford, Arizona.

NURSES—Head; for tuberculosis sanatorium in midwest; 335 beds; salary $200 per month with complete maintenance; annual salary increase, two weeks paid vacation; six legal holidays; sick leave accumulative; 45-hour week. Apply, Superintendent of Nurses, State Sanatorium, San Haven, North Dakota.

NURSES—Night supervisor, $250; general duty night nurse, $200; general duty surgical head nurse, $225; general duty surgical floor nurse, $200; new modern 39-bed county hospital; vacation and sick leave. Apply, Madison County Memorial Hospital, Winterset, Iowa.

classified advertising

POSITIONS OPEN

NURSES—Practical; graduates of schools approved by Michigan Board of Registration for nurses and trained attendants; $186 per month; 40-hour week; paid vacation, holiday time and accumulative sick time; regular pay increases. Write, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

NURSES—Recent or experienced graduates for floor duty and supervisory openings; 66-bed private hospital; 5-day week schedule. Write, John C. Richard, Administrator, East End Memorial Hospital, 7916 Second Avenue, South, Birmingham 6, Alabama.

NURSES—Registered; for 5½-day week; paid vacations; 8 paid holidays per year; permanent employment; starting salary for general duty $220 per month with $5 raise every six months for two years; maintenance is available at the hospital for $40 per month. For further information contact, Superintendent of Nurses, Yuma General Hospital, Yuma, Arizona.

NURSES—Registered; graduate; for general duty in eye, ear, nose and throat services and psychiatry; salary $225 per month for 44-hour week with increases in six months, one year and two years; $20 differential for evening and night duty; $30 per month additional for psychiatric nursing; social security provided. Apply Superintendent of Nurses, McMillan Hospital, 640 South Kingshighway, St. Louis, Missouri.

NURSES—Registered; graduate; for general duty; gives opportunities for experience in all types of medical and surgical services and specialties, including out-patient department; salary $225 per month for 44-hour week, with increases at six months, one year and two years; $20 differential for evening and night duty; $30 per month additional for psychiatry; social security provided. Apply Superintendent of Nurses, Barnes Hospital, 600 South Kingshighway, St. Louis, Missouri.

NURSES—Staff; for 150-bed hospital in state university city; starting salary $180 per month, additional $10 for PM or night duty; retirement plan and meals while on duty. Write, Director of Nursing, Burnham City Hospital, Champaign, Illinois.

NURSES—Staff; eligible for registration in Michigan; needed for all services in modern 200-bed hospital; salary $226 per month for 40-hour week; 6 months increase; $10 extra for 3-11 and 11-7 duty; 7 paid holidays; 2 weeks vacation and 12 days sick leave per year; cafeteria meal service; laundry furnished. Apply, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

NURSES—Staff; for all services; beginning cash salary, $242 per month; 40-hour week; $1 per day extra for afternoon and night duty; increase in salary every 6 months, if merited; employment standards approved by Michigan State Nurses Association. Apply, Director of Nurses, St. Joseph Hospital, Mt. Clemens, Michigan.

(Continued on page 198)

NURSES—Staff; for general hospital in medical, surgical and obstetric services; $225; also vacancies on operating room staff; salary $210 per month; two weeks' annual vacation and 12 days' annual sick leave; retirement benefits available if desired; straight 8-hour day, 41-hour week. For information write, Superintendent, Robinson Memorial Hospital, Ravenna, Ohio.

NURSES—Surgical; also general duty nurses; salary open; 5½-day week. Apply, Southwestern General Hospital, 2001 Erie Street, El Paso, Texas.

PHARMACIST — Assistant; 280-bed general hospital; prefer young girl who has completed apprenticeship; must have or be eligible for Wisconsin license. Write Personnel Department, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

RESIDENCIES—Available in medicine and pathology; 500-bed general hospital, 60 miles from New York. Apply at once to Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

RESIDENCIES—In medicine and surgery; available beginning July 1, 1951; 325-bed general hospital; approved for straight medical and surgical residency training; Board certification; salary excellent with full maintenance. Apply, President, Missouri Pacific Hospital Association, 1755 South Grand Boulevard, St. Louis 4, Missouri.

classified advertising

POSITIONS OPEN

RESIDENCIES—Applications now being accepted for residencies in medicine, obstetrics, pediatrics, surgery and urology; general hospital; approved by ACS and AMA; 500 beds. MO 19, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

RESIDENCY—Approved: in pathology and clinical pathology; 2 years; fully approved hospital; 150 autopsies, 3500 surgicals; $150 to start. Apply, Director of Laboratories, Saint Joseph's Hospital, Lancaster, Pennsylvania.

RESIDENT—General; for 125-bed general hospital; ASC approved; $200 per month. Apply, Leo N. Levi Memorial Hospital, Hot Springs, Arkansas.

RESIDENCY—In pediatric surgery; Open July 1, 1951 for 1 year, general and specialty surgery excepting orthopedics; American Board approval applied for. Write, Superintendent, Children's Orthopedic Hospital, Seattle, Washington.

SUPERINTENDENT OF NURSES—Assistant; 60-bed general hospital; new building, modern equipment; western Wisconsin, college town; vacation, sick leave, retirement plan. Apply to Myrtle Werth, R.N., Superintendent of Nurses, Memorial Hospital, Menomonie, Wisconsin.

SUPERVISOR—Assistant; for operating room of 450-bed general hospital. Apply stating qualifications and salary expected, Director of Nursing, General Hospital, Saint John, New Brunswick.

SUPERVISOR—Maternity; 18 bassinets, building; satisfactory experience and/or post-graduate training; salary open; automatic increases, 40-hour week; 2 weeks vacation after first year. MO 32, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Medical, surgical floor; 80-bed general hospital; salary open; automatic increases, 40-hour week, 2 weeks paid vacation after first year; experience and/or advanced training required. MO 33, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Obstetric; for hospital with school of nursing; degree preferred, but advanced preparation and experience will be considered in lieu of degree; salary open; liberal personnel policies. Apply, Director of Nursing, East Orange General Hospital, East Orange, New Jersey.

SUPERVISOR—Operating room; 80-bed general hospital; satisfactory experience and/or post-graduate work desired; salary open; 40-hour week, 2 weeks paid vacation after first year; automatic wage increases. MO 31, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 200)

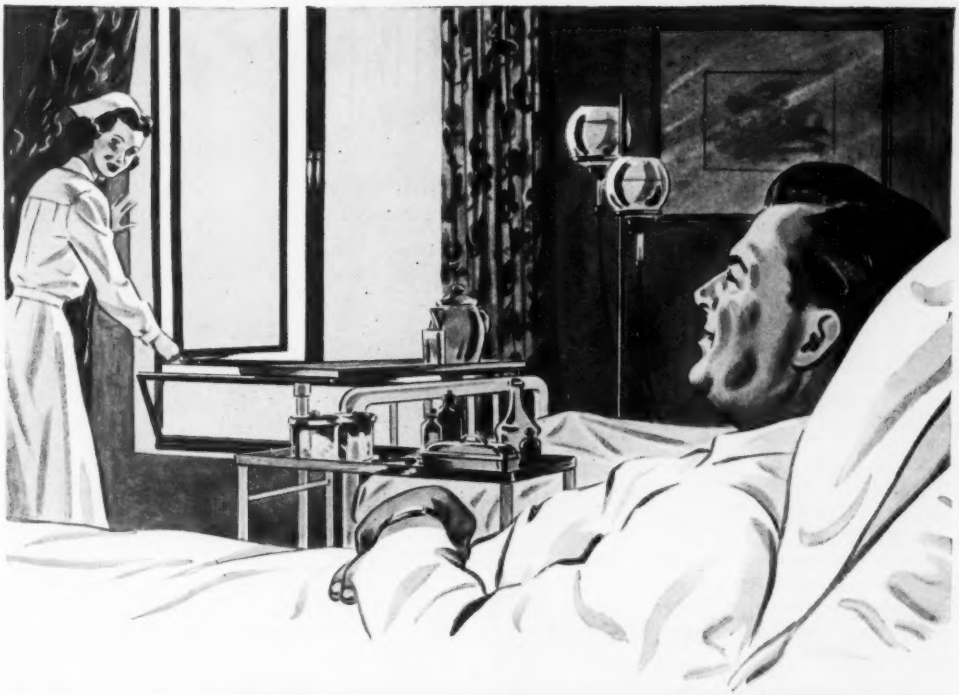
SUPERVISOR—Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

SUPERVISOR—Operating room; for 289-bed hospital with new building program; salary dependent on qualifications. Write, Director of Nurses, Hamot Hospital, Erie, Pennsylvania.

TECHNICIAN—Laboratory and x-ray combined; 23-bed hospital in a fine community; salary $250 and commission. Apply President, Community Hospital, Box 47, Lindsborg, Kansas.

TECHNICIANS—Laboratory and x-ray; must be registered; 35-bed general hospital, female only; maintenance available; salary $300 per month. Apply, Safford Inn Hospital, Safford, Arizona.

TECHNICIAN — Laboratory; experienced; registered; modern east side hospital; good hours and salary; pleasant surroundings; 40-hour week. Jennings Memorial Hospital, 7815 E. Jefferson Avenue, Detroit 14, Michigan.



HOW TO PEP UP PATIENTS

Ever lie there yourself and feel the room slowly clamp down on you? Nothing to look at but four cold walls and the too-familiar face of the ceiling. Nothing to think about but how lousy you feel.

Why not open up that room with a big-view Fenestra* Steel Window? Let the action and interest of the view come in. Let the warm cheerful light of the sun flow over the room. Let controlled ventilation wash it fresh and clean.

Standardized Fenestra Intermediate Steel Windows have cleverly designed frames—time-proved for strength and rigidity—that permit *more glass* per window . . . more *light* . . . more *view*.

And a nurse can control ventilation—with one hand. The graceful vents protect against drafts and give you controlled ventilation . . . in any kind of weather. These wonderful windows are washed and screened from *inside*. And their graceful lines give your hospital architectural distinction—inside and out.

Fenestra Galvanizing Slashes Window Maintenance Costs

No more painting! Fenestra's special hot-dip galvanizing completely protects Fenestra Windows. It's done in Fenestra's own new plant with special tanks, special automatic controls, where everything is geared to give you the most *permanent* windows made.

Compare Fenestra's triple savings: Low first cost . . . volume production. Low installation cost . . . modular sizes. Low maintenance cost . . . steel *lasts*. Choose standardized Fenestra Intermediate Steel Windows . . . engineered to cut the waste out of building.

For further information, call the Fenestra Representative (he's listed under "Fenestra Building Products Company" in your Yellow Phone Book), or write to Detroit Steel Products Company, Dept. MH-8, 2258 East Grand Blvd., Detroit 11, Michigan. *®

And ask for your free book on how Fenestra Super Hot-Dip Galvanizing makes Fenestra Steel Windows *stay* new.

Fenestra

DOORS • WINDOWS • PANELS

engineered to cut the waste out of building

See our exhibit at the A.H.A. Convention, St. Louis, Mo., September 17-20

classified advertising

POSITIONS OPEN

TECHNICIAN—Laboratory; for 30-bed hospital; Texas border town; must be registered in Texas; male or female; preferably single; salary open. Apply, Memorial Hospital, Eagle Pass, Texas.

TECHNICIAN—Laboratory; registered desirable, but inquiries of apprentice technicians will be considered; salary open; 187-bed general hospital; 15 miles from Pittsburgh; with or without full maintenance. Apply, Sewickley Valley Hospital, Sewickley, Pennsylvania.

TECHNICIAN—X-ray and laboratory combined; female; salary $250 with complete maintenance. Apply, Superintendent, State Sanatorium, Basin, Wyoming.

TECHNICIAN—X-ray; female; 135-bed hospital; good salary offered. For particulars write, Sister M. Constance, St. Agnes Hospital, White Plains, New York.

TECHNOLOGISTS—Medical laboratory; registered; ASCP or eligible; 3 general; salary open. Write, Dr. J. Woodson Creed, Pathologist, Magic Valley Memorial Hospital, Twin Falls, Idaho.

OUR 55th YEAR

WOODWARD
Medical Personnel Bureau
FORMERLY AINGE'S
3rd floor • 185 N. WABASH AVE. CHICAGO • 1
• ANN WOODWARD • *Director*

ADMINISTRATORS—(aa) Lay: foreign appointment, large city in country of near East; 178-bed AHA approved hospital; affiliate with university medical school operated under American auspices; 2 year appointment. (a) Lay; 300-bed, general, well endowed, approved hospital; very desirable west coast college town, 120,000; minimum $12,000; (b) Lay; to direct seven 50-100 bed hospitals; islands east of the Philippines; under United Nations; some traveling; $8000; also assistant administrators for each hospital; $5000. (c) Lay; 225-bed, brand new general hospital; excellent winter, summer, resort area; southwest. (d) Lay; 75-bed, general, voluntary hospital; large building program underway; attractive southern town 15,000. (e) Lay; brand new 100-bed community hospital; requires person able to open; excellent town, 25,000; south. (f) Lay; 70-bed voluntary, general hospital planning new wing; prefer younger man with personality and good mixer; substantial salary; smaller town in agricultural northwest. (g) Lay; two general voluntary hospitals, 44 and 66 beds respectively; lovely town 6000 in beautiful Minnesota resort area. (h) Lay; half-million dollar 50-bed hospital, starting construction; require administrator soon;

(Continued on page 202)

WOODWARD—*Continued*

rural community of south. (i) Lay; brand new 50-bed general hospital; substantial salary with regular advances; lovely small college community; central. (j) Lay; new non-profit general hospital without county or governmental aid; 50 beds; health resort smaller town of south. (k) Lay; 60-bed general college hospital; attractive town; Pacific Northwest. (l) Lay; medium size, California general voluntary hospital; desirable town 15,000.

ADMINISTRATIVE STAFF APPOINTMENTS—(a) Accountant; full charge; able to assume assistant administrative duties; 85-bed general hospital; lovely midwest college town, $15,000. (b) Credit manager; with some accounting experience; 100-bed hospital opened 1949; lovely west mountain town, 12,000. (c) Office manager; 300-bed general hospital; Chicago area. (d) Business Manager; male or female; should be experienced in credits, collections and admitting; 75-bed general hospital with building program under way; Ohio. (e) Business manager; books, payroll, purchasing; eminent psychiatric 60-bed hospital; psychiatric experience desirable; large university city; central; to $7200.

ASSISTANT DIRECTORS OF NURSES—(a) 250-bed approved teaching hospital; west coast metropolis; top salary. (b) Large, approved tuberculosis hospital, adjacent New York college town and resort region; $4500 minimum. (c) 100-bed approved general hospital, eastern university town; $3600 minimum. (d) Large mental hospital, pleasant residential community, forty miles from New York City; $4200 up. (e) Large approved, general, teaching hospital; Ohio college town; $4200 minimum.

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

ADMINISTRATIVE AND ADMINISTRATIVE STAFF APPOINTMENTS — NURSES. (a) Small, general hospital; rural community; South Dakota. (b) General voluntary hospital soon expanding to 40 beds; delightful California town, 100,000. (c) Brand new 50-bed general hospital to open soon; excellent, much sought after college town, 100,000; central. (d) Brand new osteopathic hospital; do major surgery; excellent community, 200,000; west. (e) Fully approved 50-bed general church related hospital; residential town, 6000; substantial salary; midwest. (f) Two year old 50-bed general hospital; residential smaller town; health resort area; south. (g) Personnel director; 250-bed, voluntary general hospital to open soon; excellent city, 150,000; north-central. (h) Well equipped, smaller general hospital; attractive community, 4000; Minnesota. (i) New 30-bed general hospital nearing completion; summer resort area of upper New York. (j) Business manager; general hospital increasing to 135 beds; excellent town; Ohio. (k) 50-bed general hospital; new building; desirable smaller residential community; Pennsylvania. (l) Excellent brand new 30-bed general hospital opening soon; attractive college town, 6000; north central. (m) 50-bed general hospital; town, 10,000; Wisconsin. (n) Credit manager; 100-bed general hospital; town, 12,000; Wyoming.

WOODWARD—*Continued*

ANESTHETISTS—(a) Excellent small general hospital; southern city, 120,000; $4800 plus profit sharing plan. (b) Small church related hospital; $4800; exciting, interesting life in Alaskan town, 10,000. (c) For private office of famous facial surgeon; university, winter resort city, 50,000; southwest; substantial salary; pleasant conditions. (d) Large, fully approved California general hospital; near San Francisco. (e) Large general hospital in attractive Hawaii. (f) 2 year foreign appointment; large American company; $4680 plus $2400 cost of living bonus. (g) New 100 bed general hospital; $450; well located Illinois town. (h) Outstanding 20 man group-clinic; $400-$500; university town, 50,000; midwest. (i) Small general hospital; $425 plus attractive apartment; large city, Wisconsin.

DIETITIANS—(a) 100-bed hospital, northern California; $4000. (b) Small approved general hospital, Florida resort city; $3600. (c) 300-bed Ohio hospital; $4000 up. (d) Small, approved, general hospital, excellent location near Oregon Pacific coast; (e) Large, approved, general hospital; southern capital and university city; $3600 up. (f) 200-bed approved tuberculosis hospital, southern Wisconsin; $4000 up. (g) Assistant; 200-bed approved hospital adjacent east coast university town; $3600 up.

DIRECTORS OF NURSES—(a) 70-bed tuberculosis sanitarium, exclusive Chicago suburb; $3500 maintenance. (b) Large mental hospital, beautiful setting, prosperous midwest community; $5400. (c) 200-bed fully approved

(Continued on page 204)

WOODWARD—*Continued*

teaching hospital; Indiana educational center; $4500 minimum. (d) 100-bed Kentucky hospital with expansion program; $4500 maintenance. (e) 150-bed approved Michigan hospital; $4800 maintenance. (f) Small approved New York hospital; excellent Hudson River location; $4800 maintenance. (g) 250-bed approved Ohio hospital; $4800 maintenance. (h) Large, Ohio teaching hospital; pleasant college community; $6000 yearly. (i) Southwestern university school of nursing; salary to $7200 yearly. (j) Small, new Texas hospital; to $5000. (k) Small, new hospital, southeastern state capital and college town; $4200 minimum.

EDUCATIONAL DIRECTORS — (a) 200-bed approved hospital, Florida resort town; $4000 maintenance. (b) Large, general, teaching hospital; excellent location suburban community adjacent east coast educational and medical center; $3500 maintenance. (c) 200-bed approved teaching hospital; city, 200,000, not far from Detroit; $4500 up. (d) 800-bed teaching hospital; five year degree granting nursing course; $5500. (e) Large, mental, teaching hospital; eastern location; $3000 up.

INSTRUCTORS—(a) Clinical; large Pennsylvania hospital; $3750 yearly. (b) Nursing arts; southeastern university hospital; $4000 up. (c) Science; 100-bed Massachusetts hospital, city, 25,000 adjacent Boston; $3600 minimum. (d) Psychiatric; large, eastern psychiatric hospital; Philadelphia area; $3300 minimum. (e) Social Science; 250-bed approved hospital vicinity Pennsylvania state capital; top salary.

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) Large, approved, teaching hospital; south eastern medical center; $3500 minimum. (b) New hospital for post-operative care, unusually attractive location, elite beach resort area of far out Long Island; salary open. (c) 250-bed approved hospital, Texas university town; top salary. (d) New, ultra-modern hospital, city, 35,000, vicinity south eastern state capital and university town. (e) House manager and housekeeper; Wisconsin college; salary open. (f) 50-bed tuberculosis sanitarium, resort town, 10,000, vicinity Milwaukee.

MALE NURSES—(a) First aid man; new air conditioned hospital; American owned project interesting location Persian Gulf; $3600. (b) 150-bed general hospital; attractively situated 50 acres of landscaped grounds on Staten Island, New York, adjacent numerous shore resorts. (c) 135-bed modern prison hospital, southeastern capital; opportunity for advancement; $3600 increasing to $3960.

PHARMACISTS—(a) New 200-bed hospital; excellent location southeastern Virginia near state capital; $5400. (b) 50-bed clinic-hospital noted Michigan resort city, fifty miles from Chicago; $5000. (c) 75-bed general hospital vicinity midwest state capital; $4800. (d) Extensive medical center, pleasant east central location, university affiliation; $4200. (e) 200-bed approved hospital, prosperous community, good Lake Michigan location southeastern Wisconsin; $3600 minimum.

WOODWARD—*Continued*

RECORD LIBRARIANS—(a) Chief; large west coast university hospital; $4000 up. (b) Large Chicago hospital; $4500 up. (c) Western university hospital; $4200 minimum. (d) Southeastern university hospital; excellent location city, 25,000.

SUPERVISORS—(a) Obstetrical; 125-bed new, general hospital; Pacific northwest; $3300 up. (b) Operating room; 200-bed California hospital; minimum $4000. (c) Operating room; new, modern hospital, adjacent midwest college town; $4800. (d) 200-bed approved Michigan hospital; top salary.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

ASSISTANT ADMINISTRATOR — Young physician to be in charge of professional services; 500-bed general hospital; excellent salary.

ANESTHETISTS—2; 450-bed general hospital; employ several; $360, plus complete maintenance; ideal working and living conditions.

DIRECTOR OF NURSING—Under 50; 400-bed general hospital; large university city; midwest.

ASSISTANT DIETITIAN—ADA, to head special unit; 200-bed general hospital; start, $3600.

(Continued on page 206)

MEDICAL PERSONNEL EXCHANGE
—Continued

EDUCATIONAL DIRECTOR—250-bed general hospital; western Pennsylvania.

EXECUTIVE HOUSEKEEPER—300-bed hospital; New England; 5-day 40-hour week; to $3300.

No charge for registration

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

COMPTROLLER—East; 450-bed hospital in city of 90,000; charge of entire financial department; should have experience with inventory and stock control records and a thorough knowledge of hospital operations; $7000.

ACCOUNTANT-FRONT OFFICE MANAGER—Middle west; 125-bed hospital in city of 50,000; require a person who meets people well and willing to assume a considerable portion of the accounting plus supervision of a very competent staff of six; $350 to start.

DIRECTORS OF NURSES—(a) Southwest; 300-bed hospital, part of university medical center; four-year nursing course; $7200. (b) Middle west; 200-bed hospital fully approved; $4800 plus modern 3-room apartment. (c) East; 270-bed hospital, fully approved; $6000. (d) Middle west; tuberculosis sanitarium; supervise three teachers and 25 students in eight weeks course in tuberculosis nursing; $4800 with maintenance.

classified advertising

POSITIONS OPEN

SHAY—*Continued*

CHIEF DIETITIAN—East; 350-bed hospital, fully approved; ADA plus considerable experience required; complete charge of dietary department with full authority; $4200 to start plus complete maintenance.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

ANESTHETIST—Oregon; a 50-bed community in southern Oregon needs a well qualified anesthetist; starting salary $350 with early increase to $375.

ANESTHETIST—CHIEF NURSE; for small mining company hospital in Arizona; duties in anaesthesia not heavy but must have had good experience; will have charge of staff of seven nurses and two aides; salary $375 with increase to $400, room and board $34; 48-hour week.

ANESTHETIST—Industrial and community hospital of 75 beds not far from Los Angeles; $360 base pay for 40-hour week but extra for call; alternate week-ends with another anesthetist.

BUSINESS AND MEDICAL REGISTRY
—Continued

ADMINISTRATOR—For Public Health Department of one of the western states; duties involve inspection and certification for licensure of hospitals and related institutions throughout the state; a man with a degree and a year's successful completion of post-graduate work leading to certification as hospital administrator with two years' administrative experience required; salary $450.

PUBLIC HEALTH NURSE — Southwestern state; must be registered nurse with post-graduate work in public health nursing and experience or have a degree and training as public health nursing; salary $300.

EENT SUPERVISOR—One of Oregon's finest hospitals; preferably someone with post-graduate work in EENT but will consider supervising experience in that department; excellent salary.

STAFF NURSES—Nevada; starting salary $250 a month with maintenance, early increase to $275, holidays and vacation; county hospital near Las Vegas, Boulder Dam and Lake Mead; opportunity for night life, hunting, fishing and water sports.

SURGERY NURSE—Private general hospital of 60 beds located on scenic Monterey Peninsula south of San Francisco; operating room staff consists of supervisor, two registered nurses and two aides; salary $260 for 40-hour week, extra for call; maintenance at cost.

BUSINESS AND MEDICAL REGISTRY
—Continued

DIETITIANS—(a) Chief dietitian for 350-bed hospital near San Francisco; an excellent connection; $325. (b) Chief dietitian; 100-bed community hospital; city of 75,000; 225 miles northeast of Los Angeles; $300. (c) For new tuberculosis hospital in southern California winter resort area; $250.

Nurses registered in other states may now work in California Hospitals without registering in this state.

INTERSTATE HOSPITAL
AND PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

COMPTROLLERS—(a) 450-bed hospital, New York state; $7,000. (b) Accountant; 185-bed hospital; college town, Kansas. (c) 100-bed hospital, southern Ohio. (d) 400-bed hospital; northwest.

BUSINESS MANAGERS—(a) 110-bed hospital; private; Michigan; $6,000. (b) 100-bed new Ohio hospital. (c) 100-bed hospital; central Pennsylvania. (d) 75-bed hospital; Kentucky.

(Continued on page 208)

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

DIRECTORS, SCHOOL OF NURSING—(a) 200-bed hospital; suburb, New York. (b) 300-bed hospitals, Ohio, Carolinas, Florida, Illinois, Texas, New Jersey.

DIRECTORS—Nursing Service. (a) 400-bed outstanding church hospital; mid-western city; $4500. (b) 100-bed new hospital, near Philadelphia. (c) 150-bed hospital; Illinois.

PURCHASING AGENTS — PHARMACISTS. (a) To organize new department; 75-bed hospital; college community; central state. (b) 175-bed hospital; Illinois; $350, maintenance.

CHIEF X-RAY TECHNICIANS—(a) 400-bed hospital; southwest. (b) 250-bed Ohio hospital; school for x-ray students.

RECORD LIBRARIANS—(a) 300-bed hospital; eastern city; $4500. (b) 125-bed Ohio hospital; $225, maintenance. (c) Private clinic; southwest; $250.

OCCUPATIONAL THERAPISTS—$4,000.

TECHNICIANS—Laboratory: $250-$325.

DIETITIANS—(a) Chief; 175-bed eastern hospital; $375, maintenance. (b) 200-bed hospital; Ohio; modern kitchens; $350, maintenance. (c) Therapeutic; $225-$250.

The Medical Bureau

PALMOLIVE BUILDING — CHICAGO

ADMINISTRATORS—(a) Voluntary hospital, general, fairly large size; considered one of the leading on the Pacific Coast. (b) Voluntary hospital, 400 beds; large city, university medical center, midwest. (c) Associate medical director; large teaching hospital; east. (d) Teaching hospital operated under American auspices in Far East. (e) General hospital; medium bed capacity; coastal city, California. (f) Lay; group of hospitals serving community of 50,000; well equipped, modern; east. (g) New modern hospital, 100 beds; college town, south. (h) One of the country's leading private practice clinics; staff of 40 specialists; university town, 100,000, west. (i) Executive secretary; state, hospital associations. (j) Assistant; 700-bed hospital, expansion program will increase over 1200; opportunity excellent experience; university medical center; west. (k) General hospital, 250 beds, currently under construction; completion next summer; preferably someone available by October; midwest. MH8-1

NURSE ADMINISTRATORS—(a) General hospital; small size; currently under construction; town, 50,000 Pacific Northwest. (b) Children's home; college town, 100,000 midwest. (c) New hospital, 70 beds; east. MH8-2

(Continued on page 210)

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Two; 30-man clinic, all Diplomates or eligible; department directed by medical anesthesiologist; university town; $400-$500. (b) Modern general hospital serving employees, large American company in Asia; $500 which includes maintenance allowance. (c) Small general hospital; $450, apartment, Wisconsin. MH8-3

DIETITIANS—(a) Chief; 300-bed hospital; foreign assignment; $6000. (b) Voluntary hospital; medium bed capacity; college town, California. (c) Chief; long-established hospital, 200 beds; near Chicago; minimum $400. (d) Nutritionist to take charge of milk laboratory and two assistant dietitians; teaching hospitals; west. (e) Two therapeutic dietitians; teaching hospital; east. (f) Chief; fairly large hospital operated by group, all board specialists; university center; east. MH8-4

DIRECTORS OF NURSING—(a) Voluntary hospital, 400 beds; well staffed, excellent faculty; university city, midwest; substantial salary, maintenance including apartment. (b) To supervise all nursing activities of one of America's major industrial companies in Asia; outstanding person required; $8600 which includes living allowance. (c) One of the country's leading hospitals for children; school for affiliates averaging 75 students; program to be established for graduate training, pediatric nursing; university medical center; east. (d) Director of nursing service; new six million dollar hospital; teaching affiliations; appoint-

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ment carries rank professor of nursing; west. (e) General 250-bed hospital; fashionable winter resort town, south; should be particularly interested nursing care; $6000, maintenance. (f) Voluntary hospital, 300 beds; no school; college town, east. (g) Director of nursing service only; large general hospital; midwest metropolis; minimum $6000. MH8-5

EXECUTIVE PERSONNEL—(a) Comptroller to take complete charge financial department, large general hospital; upper New York. (b) Business manager; approved psychiatric hospital; university center; midwest. (c) Personnel director; general hospital; Ohio. (d) Credit manager familiar with problems of medical care and costs; challenging opportunity with medical society; east. (e) Service manager; duties: supervising housekeeping, laundry, purchasing; 300-bed hospital; university town, southwest. (f) Accountant; general hospital; Chicago area. (g) Institutional engineer; qualified supervise staff of 35; large general hospital; coastal city, south. MH8-6

EXECUTIVE HOUSEKEEPERS—(a) General 300-bed hospital; man or woman; New England. (b) Beautiful new hospital recently opened for operation; 200 beds; resort area; Pacific Northwest. MH8-7

MEDICAL BUREAU—*Continued*

FACULTY APPOINTMENTS—(a) Director nursing and coordinator of health services; university conducting cooperative program in nursing education; duties: serving as liaison between university and local hospitals, directing campus health program, counseling, supervising instruction; midwest. (b) Educational director by state board; duties: surveying schools within state, improving standards; attractive location; south. (c) Coordinator, practical nursing division, junior college; college town, 200,000; midwest. (d) Nursing arts instructor and assistant educational director; important teaching hospital; university city; east. (e) Clinical instructors in pediatric and medical nursing; large, teaching hospital; west. $4000. (f) Science instructor; fairly large hospital; resort area; Wisconsin; minimum around $4000. MH8-8

MEDICAL RECORD LIBRARIANS—(a) Chief; record departments of clinics and hospital comprising medical department one of America's leading industrial companies; foreign assignment; $615, includes living allowance. (b) Chief; large, teaching hospital; should be qualified reorganize department; outstanding opportunity. (c) Chief; competent organizer required; near Chicago; $4800. (d) Assistant; large general hospital; coastal city, California. MH8-9

STUDENT HEALTH—(a) Director student health program; 200-bed hospital; winter resort town, west. (b) Student health nurse; liberal arts college; midwest. MH8-10

(Continued on page 212)

MEDICAL BUREAU—*Continued*

PHARMACISTS—(a) Pharmacist qualified to serve as assistant purchasing agent; new hospital; midwest. (b) Medical school; woman eligible. MH8-11

SUPERVISORS—(a) Chief operating room supervisor and departmental supervisors; new hospital affiliated with one of the country's leading clinics; staff of outstanding specialists; east. (b) Pediatric, EENT and psychiatric; new hospital, unit, university group; west. (c) Operating room and floor supervisors; hospitals operated under American auspices in Peru and Colombia, South America. (d) Obstetrical; new hospital; medical school affiliations; university center; west; minimum $300. MH8-12

PLACEMENT BUREAUS

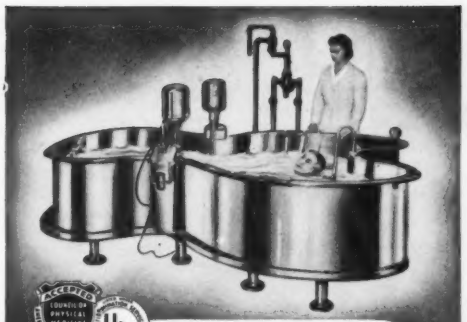
ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 2, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.



Full Body Immersion Hydrotherapy Tank Unit—Model HM-801

ILLE

Hydromassage Subaqua Therapy Equipment

Precision-engineered for hospitals, rehabilitation centers, industrial clinics and physicians' offices—ILLE apparatus is distinguished for its excellence of design, quality of materials and range of types, both portable and stationary.

Other ILLE Physical Therapy Equipment: Paraffin Baths, Mobile Sitz Bath, Folding Thermostatic Bed Tent. Detailed literature on request.

ILLE ELECTRIC CORPORATION
50 Mill Road, Freeport, L. I., N. Y.

Combination Arm, Leg and Hip Tank (an Improved Whirlpool Bath) Mobile Model HM-200

WHITEY MOPZUM SAYS:

You don't have to look at the label to identify a piece of White equipment! No sir—even a novice can see at a glance the *quality* features that make White equipment *stand out* in *any* competition—and *stand up* under *any* cleaning use. Whatever your cleaning requirements, it will pay you to insist on 'White.'

MOPPING TANKS

A BIG HELP FOR BIG JOBS!

Here's the battleship of the White fleet . . . ready to tackle the biggest, dirtiest jobs you can give it! Giant tanks of heavy 16-gauge steel with powerful crank-type wringer—mounted on angle steel frame equipped with easy running, full ball bearing casters. Rubber tires and all-around rubber bumper protects floors and walls. In 2 or 3 tank sizes up to 60 gal. capacity. Easily operated by one man—or entire crew. See your White jobber . . . send for Catalog No. 150.

WHITE MOP WRINGER CO., Fultonville 9, N.Y.

It's RIGHT . . . If it's WHITE

A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

classified advertising

PLACEMENT BUREAUS

AMERICAN NURSES' ASSOCIATION
Professional Counseling & Placement Service, Inc.

Non-fee charging Service for nurses and employers of nurses. Qualified nurse personnel and positions listed for all fields of nursing.

For local counseling and placement consult your state nurses' association. For national referral consult ANA, PC&PS, Inc. Branch Office, 8 South Michigan Avenue, Chicago 3, Illinois.

FRANCES SHORTT MEDICAL AGENCY
SPECIALISTS in the Placement of Competent Medical and Social Service Personnel.
FRANCES SHORTT, R.N., Director
280 Madison Ave., N. Y. 16, N. Y.
at 40th St. Mu 5-8935

ALLEN AGENCY
519 Hammond Building, Detroit 26
Woodward 1-7051

If you are seeking a location, write us about it. We will do an individual survey for you, if we do not have the job you want.
Are you in any of the following classifications?
Laboratory Technician, with or without ASCP registration.
X-ray Technician.
Bio-chemist and/or clinical bacteriologist.
Nurse, educational or administrative.
Dietitian, ADA.
Librarian, MRL.
Physical Therapist.
Licensed Physician.

BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

MISCELLANEOUS

CONSULTATION SERVICE
Irene M. Connors, R.R.L.
Consultation, Survey, and Organization in
Medical Record Library Science
33 Auburn Avenue, Apt. 4
Columbus, Ohio

(Continued on page 214)

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices wtih unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

Equipment for Sale—Group 1—3 used 20 x 27 x 53 Kelley-Koett x-ray metal file cabinets. Group 2—1 used 18 x 22 x 40 GE x-ray film dryer complete with motor and fan. Group 3—1 used infant Hess bed. Group 4—28 used bassinets complete with basket and mattress, 9 separate used bassinet baskets. All of the above equipment is in good usable condition; each group is to be sold only as a unit or all groups may be sold as a lot. Price reasonable. Write or call, Controller, Memorial Hospital, Elmhurst, Illinois.

---

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

WASHINGTON UNIVERSITY
School of Nursing
GRADUATE NURSE EDUCATION
Programs for 1951-1952
Leading to the degree of Bachelor of Science in Nursing:
Community Health Nursing
Psychiatric Nursing
Supervision of Nursing Service
Teaching in Schools of Nursing
Ward Administration and Teaching
For further information write to the Director, Washington University School of Nursing, 416 South Kingshighway, St. Louis 10, Missouri.

LOS ANGELES COUNTY GENERAL HOSPITAL SCHOOL OF NURSING offers a twelve weeks course in premature infant nursing to graduate nurses. The University of Southern California will grant up to six units of credit to those nurses who desire it. Course includes formal instruction, clinical experience in unit technic, teaching and public health experience. For further information write to Director, School of Nursing, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four months' course in Operating Room Technic and Management to registered graduates of accredited schools of nursing. Apply to Director of Nursing, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technic. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS —Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

THE CHICAGO LYING-IN HOSPITAL and DISPENSARY of the UNIVERSITY of CHICAGO offers a six months' course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

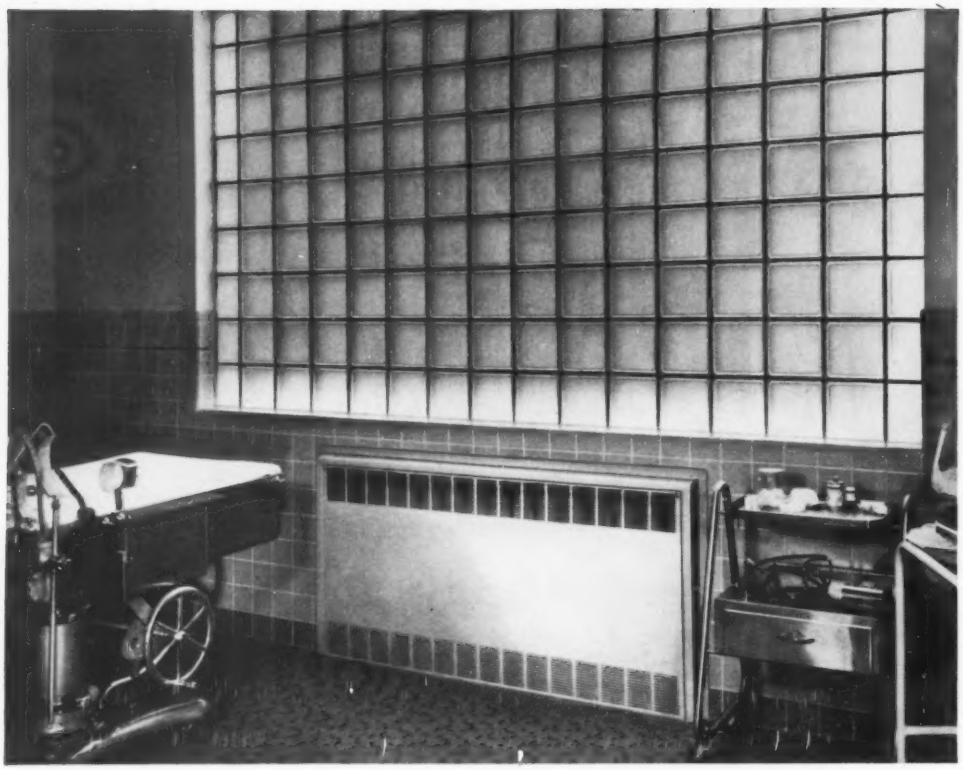
Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

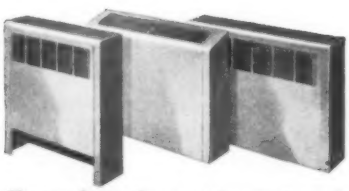
Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.



FOR FAST, DEPENDABLE HEATING

...SPECIFY MODINE INSTITUTIONAL CONVECTORS



Choose from three enclosure types!

Type IF with upper grille and choice of lower opening or lower grille . . . for either recessed or free-standing installation. Type IS and IW for wall placement. Dampers for all enclosures optional at slight extra cost.

Here's even, healthful heat . . . low-cost, trouble-free service

More and more hospitals are standardizing on Modine Convectors because they're so dependable . . . give fast, even heat when you want it, *instantly*. Modines assure you all the advantages of steam or hot water heating . . . are economical to install and maintain.

Modines are smartly styled, too . . . complement any interior treatment. And if conservation of space is one of your problems, Modine Convectors may be recessed in the walls.

Send for new Modine convector catalog today

Modine

INSTITUTIONAL CONVECTORS

For complete details, call your Modine representative . . . listed in the classified section of your phone book. Or write direct. Modine Mfg. Co., 1549 DeKoven Ave., Racine, Wis.

B-1103

First aid for physicians

Doctors, here is relief from the drudgery of seemingly endless paper work.

The AUDOGRAPH Soundwriter records patient interviews, diagnoses, post-surgical notes and instructions, and even phone calls. You have all the facts at your fingertips...eliminate tedious, time-consuming handwritten notes. Result—more time for the other important phases of your practice.

For full details on how AUDOGRAPH will save time and money for *you*, mail the coupon today. There's no obligation whatsoever.

Dictating and transcribing are E-A-S-I-E-R

with AUDOGRAPH

The "Master" Audograph: the ideal combination dictating and transcribing machine. Records on thin, lightweight, long-lasting plastic discs holding up to one hour's dictation. Operates wherever electric current is available.

Gray
AUDOGRAPH® ELECTRONIC SOUNDWRITER

AUDOGRAPH sales and service in 180 principal cities of the U.S. See your Classified Telephone Directory—under "Dictating Machines." Canada: Northern Electric Company, Ltd., sole authorized agents for the Dominion. Overseas: Westrex Corporation (export affiliate of Western Electric Export Company) in thirty-five foreign countries.

TRADE MARK "AUDOGRAPH" REG. U. S. PAT. OFF.

- THE GRAY MANUFACTURING COMPANY, HARTFORD 1, CONNECTICUT
- Send me Booklet B-P— "Saving The Doctor's Time."
- Name .....
- Street .....
- City ..... State .....

What's New for Hospitals

AUGUST 1951 Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 242. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Room Grouping

New design ideas and construction features that tend to make the furniture exceptionally practical, as well as attractive and comfortable, are incorporated in the No. 50 Room Grouping. Of modern design in all wood construction, the grouping is made of even stripe Korina, finished in No. 45 Korina. The finish is standard Hill-Rom hospital finish and the furniture is constructed to assure rigidity and long life.

A feature of the design is the streamlined effect of the bed posts and the way in which the top rail of the bed comes flush with the posts and the panel. The entire grouping has flush construction for streamlined appearance and easy maintenance. The bedside cabinet has a two-way drawer and door on both sides, there is a choice of three different dressers to be used with the grouping and an attractive dresserobe is also available. **Hill-Rom Company, Inc., Dept. MH, Batesville, Ind. (Key No. 414)**

Swivel Yarn Sweeper

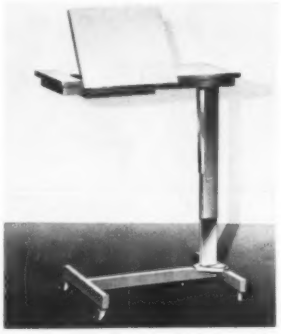
A new duster, especially useful for daily routine dusting of smooth floors, is designed to save time while doing a thorough sweeping job. The Swivel Yarn Sweeper takes up all dirt and dust and the complete mop and handle will pass under an object only 2 inches off the floor and into a narrow space 5 inches wide. The operator can stand in one spot and, with a twist of the handle, clean around and under desks, chairs, tables and equipment.

The sweeper has a galvanized steel frame, swivel action and is spot welded for durability. Handles are of lacquered hard maple and the detachable heads are of army duck cotton treated for fast dust pick-up. The heads are easily removed and replaced and are made of washable, non-shrinking canvas. **J. I. Holcomb Mfg. Co., Dept. MH, 1601 Barth Ave., Indianapolis 7, Ind. (Key No. 415)**

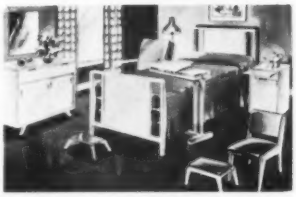
Single Pedestal Overbed Table

Sturdiness and increased top area are features of the new F-885 Single Pedestal Overbed Table recently introduced by Simmons. The large top has a full-width, movable center section which is large enough to hold a magazine when raised. The double-hinged construction of this section permits the table to be used from either side of the bed. The surface is Zalmite-finished to resist damage from heat, cold and spilled liquids.

The heavy, rectangular pedestal upright supports the top rigidly. The wide spread to the base and extra bracing clamp where base meets upright also add to the sturdiness and rigidity of the table. The table top is counterbalanced for easy lowering or raising by simply pressing the hand grip. It can be lowered to 29¾ inches for use by a patient seated in a chair and raised to any one of 15 graduated heights. The new table is available in a wide range of attractive, durable Simfast finishes. **Simmons Co., Dept. MH, Merchandise Mart, Chicago 54. (Key No. 416)**



Wood Room Group

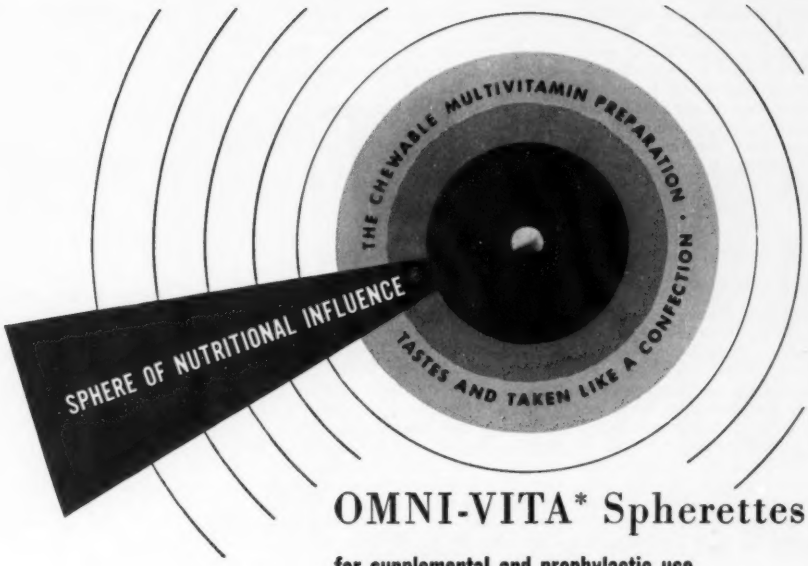


A newly-designed line of wood furniture in natural birch is being introduced in hospital room groupings. Offering the simplicity of functional modern design, the room grouping consists of bed, chest, cabinet, lounge chair with ottoman, straight chair, arm chair, screen and footstool. It is constructed of solid birch parts and 5-ply birch-faced plywood. All exposed ends are edge-veneered and all main joints are rigidly supported.

Several design features are offered in the new grouping. The bed has tapered posts and slightly curved top crosspiece. Chairs have Duran covered cushions and offset legs to prevent marring of walls. The chest has a Formica top which matches the natural birch finish, one full-sized drawer and a large flexible storage compartment. The cabinet has a Formica top and a gallery around the edge to prevent articles sliding off. A Formica covered pull-out shelf provides a convenient additional surface when desired. The footstool has offset legs with rubber glides to make it non-tip and non-slip. **Hard Manufacturing Co., Dept. MH, Buffalo 7, N. Y. (Key No. 417)**

Metal Catheter Tip Syringe

A new metal catheter tip syringe has been introduced for stomach irrigation, forced feeding of adults and irrigation of the male bladder. It has a precision fitted glass barrel and plunger with a permanently attached, tapered metal catheter tip to overcome tip breakage in use. The new B-D Metal Catheter Tip Syringe has a capacity of two ounces, graduated in ¼ ounces. **Becton, Dickinson & Co., Dept. MH, Rutherford, N. J. (Key No. 418)**



OMNI-VITA* Spherettes

for supplemental and prophylactic use

For many years, much time and effort has been given to the development of an effective multivitamin preparation which would not frighten or repel the patient by its size, disagreeable taste or odor, and unpleasant appearance. The stability of OMNI-VITA* Spherettes is assured by layering of the vitamin components. Younger patients and finicky adults, particularly, were likely to object strenuously to the average multivitamin preparation—oils, liquids, tablets, or capsules.

Warner is proud, therefore, to present OMNI-VITA* Spherettes. A delicious, chewable Spherette containing generous amounts of the vitamins—an excellent and extremely convenient means for supplying either supplemental or prophylactic doses of the vitamins most frequently low in the modern diet or involved in subclinical deficiencies.

OMNI-VITA* Spherettes have a full and balanced complement of vitamins. Each Spherette contains:

Vitamin A, Synthetic	5,000 U.S.P. Units	Vitamin B_2 (Riboflavin)	2.0 mgs.
Vitamin D (Activated Ergosterol)	1,000 U.S.P. Units	Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Vitamin C (Ascorbic Acid)	50.0 mgs.	Vitamin B_{12}, Crystalline	1.0 mcg.
Vitamin B_1 (Thiamine Hydrochloride)	1.0 mg.	Panthenol (equiv. to 1.15 mgs. d-Calcium Pantothenate)	1.0 mg.

The supplemental or prophylactic use of OMNI-VITA* Spherettes ensures the the patient's cooperation—children and adults alike.

WILLIAM R. WARNER Division of Warner-Hudnut, Inc.

New York Los Angeles St. Louis

*Trademark

Food Conveyor

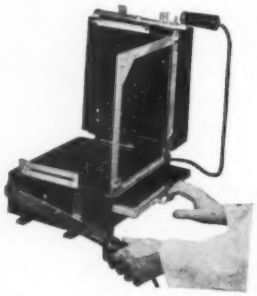
The new Diet-Master Food Conveyor is designed to permit the making of inset arrangements to fit specific needs. The various sized rectangular and square insets may be arranged to suit selective menus. In addition, two round wells are provided for soups and other liquids and two heated drawers for bread and rolls. The conveyor is made of heavy gauge stainless steel throughout and the manufacturer states that it is Underwriters Laboratories approved. **Prometheus Electric Corp., Dept. MH, 401 W. 13th St., New York 14. (Key No. 419)**

Heavy-Duty Steam Gun

Where heavy-duty steam cleaning operations are required the new Model 502 Oakite Solution-Lifting Steam Gun will be of interest. It is designed for use where range of operation pressure is 50 to 100 p.s.i., with minimum boiler rating of 25 or more h.p. recommended. With the gun, steam-detergent spray is automatically lifted 12 feet above the working level to provide thorough cleaning of large equipment and other surfaces. **Oakite Products, Inc., Dept. MH, 118A Thames St., New York 6. (Key No. 420)**

Seriograph

A new Seriograph for cerebral angiography has been designed by Dr. Solomon Fineman of New York and provides for both AP and lateral work. It utilizes four 10 by 12 inch cassettes which are changed manually. The cassette exchange and exposure trigger are designed for use



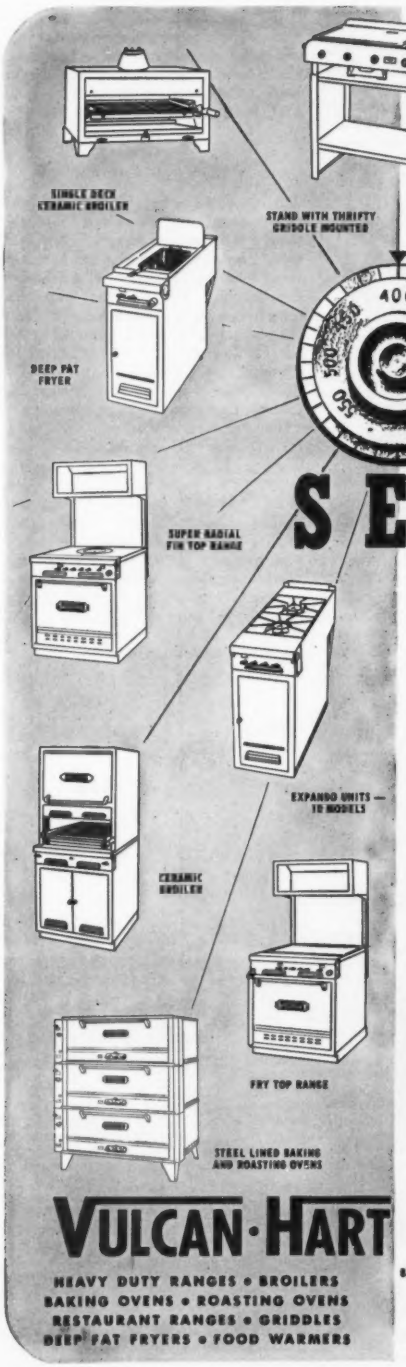
by one operator, permitting close coordination. The new Seriograph is economical in price. Accessories available include a removable lead rubber shield to protect the operator, a compression device for immobilizing the patient and a 10 by 12 inch Lysholm Grid. **Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 421)**

Acousti-Celotex Finish

A new washable finish is being incorporated into all Acousti-Celotex sound conditioning tile. The result of years of research and development by the company, the new finish is applied directly to the board under pressure, becoming an integral part of the tile. The new finish is a tough, flexible coating with a linen-like texture. It gives better light diffusion than a smooth surface although the light reflection value remains the same. **The Celotex Corp., Dept. MH, 120 S. La Salle St., Chicago 3. (Key No. 422)**

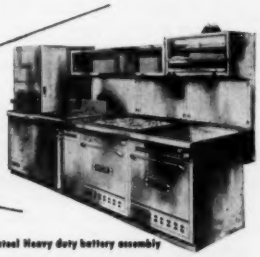
Dry Chemical Extinguisher

The Ansul 4-B is a new 4 pound dry chemical fire extinguisher with a rubber hose. It is designed for ease of operation, flexibility in fighting overhead and ground level fires and maximum extinguishing effectiveness for inexperienced operators. The new extinguisher has an operating range of 12 to 15 feet. Dry chemical is ejected through a self-closing nozzle which produces the fan-shaped stream pattern and makes the unit weather-tight. The unit is pressurized by a $1\frac{1}{2}$ ounce carbon dioxide cylinder in the dry chemical chamber. **Ansul Chemical Co., Dept. MH, Marinette, Wis. (Key No. 423)**



BIG SELECTION

makes for PLANNING PERFECTION



100% stainless steel Heavy duty battery assembly

Feeding picayunish patients—preparing a variety of foods for numerous diets—puts increasing demands on today's hospital kitchens. Kitchen engineers will be quick to tell you that "make-shift, make-do" equipment can be a big part of administrative operation costs. That's why more than ever before Vulcan•Hart is the best buy. Limitless top arrangements and unit combinations accommodate any hospital kitchen situation. If you are planning a new installation or modernizing an existing one Vulcan saves you money in time and effort by simplifying your planning problem and, after operation commences, savings in food, fuel and efficiency can mean the difference between profit and loss on your food operation. See your Vulcan dealer or write us for detailed information on Vulcan ranges especially designed for hospital use. Address 18 E. 41st St., New York 17, Dept. 14.

No. 260 Series new Restaurant range

"There's a Vulcan Hart for every cooking need"

No. 636 griddle with two No. 6120 open burner units

VULCAN·HART MANUFACTURING CO.

"MAKES THE MOST OF THE BEST"

HEAVY DUTY RANGES • BROILERS
BAKING OVENS • ROASTING OVENS
RESTAURANT RANGES • GRIDDLES
DEEP FAT FRYERS • FOOD WARMERS

Factories and General Offices:
BAYARD AND HAMBURG STS., BALTIMORE 30, MD.
2006 N. W. Parkway, Louisville 3, Ky.

Sales Offices and Showrooms:
New York • Chicago • Los Angeles • Boston
In Canada: Moffats Ltd., Weston, Ontario

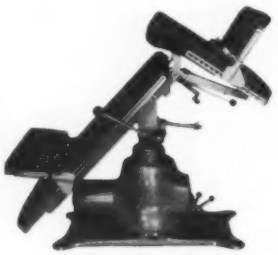
Disposable Oxygen Mask

A clear, light weight, soft-textured plastic is used to make the new K-S Disposable Oxygen Mask. It has heat-sealed seams which assure efficient operation and a pliable metal "conforming strip" holds the mask securely to the contour of the face and nose without undue pressure, gaps or wrinkles. A light elastic band comfortably holds the mask in place under the chin.

Danger of cross infection, and cleaning and sterilizing time and effort are eliminated since the mask is designed to be worn by one patient, then discarded. It has wide nostril opening and a spacious rebreathing bag to allow deep respiration in comfort, while conserving oxygen. A special porting arrangement prevents the building up of carbon dioxide within the mask. Normal atmospheric and temperature changes have no effect on the mask which can be stored indefinitely before use without endangering the material or construction. It can be used with any oxygen therapy system, since it can withstand all normal delivery pressures. It folds easily to fit a standard business-sized envelope and can be conveniently kept in bedside tables, chests or drawers in a recovery room. **Ohio Chemical & Surgical Equipment Co., Dept. MH, 1400 E. Washington Ave., Madison 10, Wis. (Key No. 424)**

Proctologic Table

The newly designed Proctologic Table, Model B, Type 7, incorporates a Ritter construction feature which automatically raises the leg section above the high line of the body section as the table is tilted, forming an abdominal drop-out area of adjustable depth. Designed in cooperation with leading proctologists, the table



is perfectly balanced, easily positioned and smoothly operated.

Standard equipment on the new table includes adjustable headrest, knee rest, snap lock adjustable leg strap on the knee rest, and hand tilt lever. A foot tilt lever may be supplied if desired. The table has a motor-driven hydraulically operated base which raises the table top from 30 to 47 inches quietly and effortlessly. The table tilts 55 degrees and rotates 180 degrees. Mobile base, explosion-proof motor, stirrups and hip rest are available as optional equipment. **Ritter Company Incorporated, Dept. MH, Rochester 3, N. Y. (Key No. 425)**

Fiberglas Fabrics

A line of 40 different design and print combinations of Coronized Fiberglas fabrics is being introduced. The hand-print draperies are woven of Fiberglas yarns made by Owens-Corning Fiberglas Corporation. They cannot burn but are permanently incombustible since they are made of spun glass. They are readily washable and do not shrink or stretch. They resist fading from sunlight, resist wrinkles and require no ironing, thus simplifying maintenance.

The present Fiberglas hand-print drapery materials are the result of long research in processes for printing the fabrics. They have bright fast colors, are soft to the touch and for draping and the many attractive print designs make them suitable for all needs in the hospital, whether private rooms, wards, sun porches, reception rooms, nurses' homes or other areas where draperies are indicated. **Whitcombe-McGeachin & Co., Inc., Dept. MH, 509 Madison Ave., New York 22. (Key No. 426)**

Multi-Purpose Uniforms

To simplify uniform purchasing and permit purchasing in larger quantities at lower prices, Angelica Uniform Company has introduced the idea of using "multi-purpose" garments. The idea is to use one style of garment in such departments as housekeeping, dietary, nurses' aid and maintenance with only a color change to indicate the department. Thus orders for different departments may be combined and purchases made from the one source. One suggested uniform for this purpose consists of a Monte cloth pinafore in choice of gray, aqua, yellow or rose with a white broadcloth blouse. Many other styles are available and are shown in color in the Angelica Hospital Apparel Catalog. **Angelica Uniform Co., Dept. MH, 1419 Olive St., St. Louis 3, Mo. (Key No. 427)**

Upholstery Shampoo Machine

A new All-Automatic Upholstery Shampoo Machine has been introduced with a light, motor-driven applicator brush unit weighing only 5½ pounds. It is easy to use on vertical as well as horizontal surfaces and has simple finger controls for electric current and flow of cleaning solution. The cleaning solution is fed by air pressure from the 5 gallon tank to the applicator brush. Constant air pressure is automatically maintained by a micro-switch. The solution is "pre-sudsed" by air pressure and lathering is completed by the rotary brush action. This permits shampooing with "dry" suds for more thorough cleaning, less splattering and minimum wetting of the fabric.

The new Hild All-Automatic is easily portable and has 20 feet of hose as standard equipment. All fittings that come in contact with the cleaning solution, as well as the tank itself, are made of corrosion-resistant metal and the brush has nylon bristles. **Hild Floor Machine Co., Dept. MH, 740 W. Washington Blvd., Chicago 6. (Key No. 428)**

Precooked Cereal

Pablum, the name for the line of precooked cereals developed by Mead, Johnson and Company, is now available in two new forms. Pablum Rice Cereal is a hypoallergenic cereal food in an easily digested, flavorful form. Pablum Barley Cereal has preserved the natural flavor of barley. These additions to the Pablum line are easy to digest and are enriched with vitamins and minerals. **Mead, Johnson & Co., Dept. MH, Evansville 21, Ind. (Key No. 429)**

Uni-Mac Laundry Unit

The Uni-Mac laundry unit is a single unit 44 inches square which is divided into four parts, three with agitators and one for jet-rinse and extractor use. The Uni-Mac is suitable for small hospitals or for nurses' homes. Each of the four units operates independently so that any one or all of them may be used at the same time. The total capacity is from 30 to 45 pounds of wash completed in approximately a half hour.

The machine is well constructed for hard use, occupies only 44 square inches of floor space, is economical and efficient in operation. **The C. P. Clark Co., Dept. MH, P. O. Box 2251, Fort Lauderdale, Fla. (Key No. 430)**

Mobile Kardex

The new Remington Rand Mobile Kardex can house all cost, personnel, credit, ledger and other records. The new unit can be moved, grouped and arranged for the greatest efficiency, regardless of floor layout, and can be made available at the point of use and convenience with a minimum of effort. All records in Mobile Kardex are visible, for faster use, and all writing and transcription are done at comfortable working level.

Equipped with ball bearing, hard rubber casters, Mobile Kardex can be moved right to the person needing information. The unit can be easily rolled into the vault for overnight storage if desired. Where mobility is not required, Mobile Kardex can be provided with a stationary angle base. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 431)**

Improved Broiler

The Garland broiler has been improved in design to accomplish even better broiling. A new 14 inch back flue has been put in to provide more positive and effective control of smoke vapors. The heavy ceramic radiants, a Garland feature, evenly distribute intense heat from two separately controlled multi-port burners. The new "floating" grid rods can expand under intense heat and so prevent warping. The exterior has been redesigned with an unbroken front to make cleaning faster and easier. A deeper oven area is another feature of the new model. **Detroit-Michigan Stove Co., Dept. MH, 6950 E. Jefferson St., Detroit 31, Mich. (Key No. 432)**

Ice Cube Machine

Model A5A-4 is a new addition to the line of ice cube machines made by Ajax Corporation. The new unit has the same type of freezing mechanism as the Model A5A-2 with an additional larger storage bin which holds 150 pounds of ice. The storage bin is so designed that the oldest ice can be used first. The unit also has a new type mechanical storage bin control which simplifies service and maintenance. The ice can be easily removed through a waist height counterbalanced door.

The Ajax Electric Iceman is powered with a Servel Supermetic compressor. The cabinet has blue-gray hammerloid finish which is tough and durable and blends with its surroundings. **Ajax Corporation of America, Dept. MH, 2509 Washington Ave., Evansville, Ind. (Key No. 433)**

Improvements to Magic Chef Line

The Magic Chef Cafe line ranges are now available with automatic oven lighting and safety oven pilots as optional equipment. The compact pilot unit fits snugly in the inside lower left-hand corner under the range base and lights through the regular oven bottom lighter port. It is available for all gases and incorporates 100 per cent shutoff for complete safety. General Controls automatic lighting equipment is used. **American Stove Co., Dept. MH, 1641 S. Kingshighway Blvd., St. Louis 10, Mo. (Key No. 434)**

Growth Rates
AND IMPROVED NUTRITION

ACCORDING to an eminent authority,[1] increased growth rates of children are largely attributable to improved nutrition; also, "much evidence exists that current diets are often unsatisfactory." The nutrients most commonly deficient in diets of children are protein, calcium, thiamine, riboflavin, and ascorbic acid.

Ovaltine in milk—a palatable food supplement, readily accepted by children and easily digested—presents an excellent means of helping to bring even grossly deficient diets to optimal nutritional levels. It provides a wealth of biologically adequate protein, easily emulsified fat, readily utilized carbohydrate, and essential vitamins and minerals. The addition of three servings daily to the child's diet, either at mealtime or between meals, assures nutrient intake in keeping with the dietary allowances of the National Research Council—an essential for promoting optimal growth rate.

The nutrient contribution of three servings of Ovaltine in milk is defined in the appended table.

1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. *142*:806 (Mar. 18) 1950.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk, provide:*

PROTEIN	32 Gm.	VITAMIN A	3000 I.U.
FAT	32 Gm.	VITAMIN B_1	1.16 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

Joanna Wall Covering

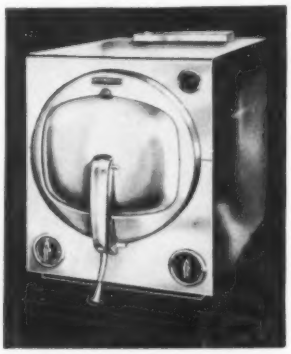
A new vinylized fabric wall covering is being introduced for use where durability, washability, fire-resistance and attractive appearance are important. Joanna Wall Coating employs a newly perfected vinyl plastic coating applied to a supporting cotton fabric. The resulting material is resistant to scuffing and abrasion, is stainproof and is easily hung. It may be washed with any kind of soap and water or with detergents. The covering is fire resistant as it contains no oils or other inflammable ingredients and when subjected to a blow torch after it was hung, the flame died immediately the torch was removed.

Joanna vinylized wall fabrics are now available in 28 attractive colors with texture embossing or overprints. **Joanna Western Mills Co., Dept. MH, 22nd and Jefferson Sts., Chicago 16. (Key No. 435)**

Steam Pressure Cooker

A new direct connected Steam-It Commercial Pressure Cooker has been added to the regular line of compartment steam cookers offered by the Market Forge Company. Similar in appearance to the gas fired Steam-It, the new unit is directly connected to an existing steam line. Thus it is supplied from steam available at the point of installation, permitting pressure cooking to begin at once.

Designed for small quantity cooking, the unit permits frequent fresh preparation of smaller quantities of food where direct steam is available for cooking.



Steam-It may be used for all types of food as a complete cooker or as a precooker. Natural flavors and colors of foods are unchanged, and the unit is easily cleaned. **The Market Forge Co., Dept. MH, Everett Station, Boston 49, Mass. (Key No. 436)**

Pneolator

The Pneophore, an automatic breathing apparatus described in the February 1949 issue of "What's New for Hospitals," is now available in portable form. Designed for emergency use and known as the Pneolator, it is contained in a strong but light case containing the artificial respiration instrument, a small tank of oxygen capable of supplying oxygen needs for approximately 90 minutes, the half-mask facepiece, flexible breathing hose and other equipment required to operate the device.

The principle employed in the automatic breathing apparatus is that of positive pressure only, thus when the oxygen supply shuts off, the victim exhales by relaxation of lung walls and diaphragm muscles, removing the possibility of harm to lung tissues. The intermittent positive pressure breathing valve can be set for any desired need, depending upon the age and condition of the patient. The unit can be attached to a large standard tank of oxygen where available. While the Pneophore is designed for hospital use, hospital executives will be interested in the availability of the Pneolator, the portable model which is designed for use in ambulances and in emergencies. **Mine Safety Appliances Co., Dept. MH, 230 N. Braddock Ave., Pittsburgh 8, Pa. (Key No. 437)**

Sterilwrap

Sterilwrap is a disposable replacement for fabric in preparing a sterile pack for autoclaving. It is a cloth-like crepe material specially treated to ensure high wet strength and full steam penetration. It will not stiffen or crack, provides maximum sterility retention and has long shelf life. Materials wrapped in Sterilwrap are completely sterilized under the same autoclaving conditions used with textile wraps.

Sterilwraps are design primarily as disposable wraps which can be discarded after one use. This eliminates excess handling, reduces storage space requirements and eliminates laundering. However, the product can be used more than once if desired. It is available in sheets of various sizes as well as in glove envelopes, envelope cases and tubing for wrapping such items as catheters. **Meinecke & Company, Inc., Dept. MH, 225 Varick St., New York 14. (Key No. 438)**

Diagnostic Kit

The new Diagnostic Kit introduced by Ames Company provides, in a single compact unit, material for acetone, albumin, occult blood and urine-sugar tests. The kit contains 100 Acetest Reagent Tablets, 32 Bumintest Reagent Tablets, 36 Clinitest Reagent Tablets and 60 Hematest Reagent Tablets. With these are 6 test tubes, 3 droppers, Bumintest reagent bottle, dropper service water bottle, plastic rack, combination color chart and instructions for use. The kit provides the means for making reliable tests quickly, easily, conveniently and economically. **Ames Company, Inc., Dept. MH, Elkhart, Ind. (Key No. 439)**

Bed Elevator

A hydraulic unit for raising the end of the patient's bed without strain or effort is offered in the Bed-El-Vator. With this unit are provided Bed-El-Vator Stilts which are placed under the legs of the bed at the desired height. The Bed-El-Vator fits against the bed without projections, thus eliminating the possibility of accident. The Bed-El-Vator Stilts are adjustable to any desired height, preset and available in any quantity required for elevating either end or the entire bed. When set in place they remain firmly adjusted until removed.

The elevator is built of steel and cast aluminum for strength and lightness, is light in weight and easy to operate. The swivel bracket rack rotates 360 degrees for instant and close positioning. The unit is mounted on a mobile base equipped

with four swivel casters. **United Surgical Supplies Co., Dept. MH, 160 E. 5th St., New York 22. (Key No. 440)**

Air Diffusers

A new line of high-pressure, aspirating air diffusers (Type HPW-1) has recently been introduced. Available in three sizes, the HPW-1 design is a pre-induction type unit which induces room air, mixes it with the primary air in approximately equal proportions and discharges the mixture through an aspirating air diffuser. The new units can be used on air distribution systems which carry air at velocities up to 5000 fpm and static pressures up to 6 in. wg. High temperature differentials can be handled and temperature difference between primary air and ambient or room air is limited only by dew point to avoid condensation. Air volume can be manually or automatically controlled. **Anemostat Corporation of America, Dept. MH, 10 E. 39th St., New York 16. (Key No. 441)**

Pillow Reception Radio

The improved Philtain Pillow Reception Radio fastens to the patient's bed with a padded clamp bracket which will not mar or scratch the finish. The bracket is quickly and easily fastened to the back of the headboard and is not seen from the front. Swivel action assures instant use of the radio as the patient desires while permitting it to be swung completely out of the way during nursing service or examinations.

The Philtain has a 3 inch disc speaker which fits smoothly under the pillow for good individual reception without disturbing others in the room. A coin slot located on the front of the radio

for patient convenience holds dimes, each of which permits the radio to run for one hour, continuously or intermittently. The hospital makes no investment in the Philtain Radio. It is installed and serviced by the company which turns over to the hospital 25 per cent of the total gross revenue, thus making the radios an additional source of hospital income. As part of the service, a lobby display informs visitors of the personalized radio service. Cards are provided in which visitors may insert dimes to leave with the patient in lieu of other gifts. **The Amscro Corp., Hospital Radio Div., Dept. MH, 1115 S. Clinton St., Ft. Wayne 2, Ind. (Key No. 442)**

Seal and Varnish Stripper

Multi-Clean Seal and Varnish Stripper is a non-inflammable product designed to remove all types of varnish, seals, shellac, enamels and paints thoroughly and safely. It works equally well on wood, concrete or terrazzo floors, lifting the old finish away from the surface in a dry and dustless form for easy pickup with a broom or vacuum cleaner. The product leaves no wax or objectionable residues, thereby eliminating the necessity for further washing of the floor before refinishing.

If the stripper is applied at night with an applicator or brush, the finish can be removed the next morning with a steel wool pad under a floor machine. If more speed is desired, it can be easily applied, left on 30 to 40 minutes, the finish lifting off readily with the aid of steel wool or scraper. **Multi-Clean Products, Inc., Dept. MH, 2277 Ford Pkwy., St. Paul 1, Minn. (Key No. 443)**

Toilet Tissue Holder

Considerable saving in toilet tissue is a feature of the new Permco Paper Saver Toilet Tissue Holder. It is also designed to keep the tissue sanitary by preventing it unrolling or falling on the floor. The holder dispenses only two sheets at a time. The paper roll is snapped on, locked, and cannot be removed until the roll is empty.

Elongated screw holes in the Permco Holder make it easy to attach it to the wall. It is made of steel, aluminum or chromium plate, in one piece, with no springs or removable parts. It is a permanent fixture which operates simply, is rust resistant, durable and should require no maintenance or repairs. The patented locking device prevents removal of rolls of toilet paper, thus preventing petty theft as well as waste. Any size roll of paper fits the holder. **National School Supply Co., Inc., Dept. MH, Raleigh, N. C. (Key No. 444)**

Disposable Patient Robes

Examining robes which can be discarded after each use are now available. Known as Dispos-A-Robes, they are made of water repellent, pliable, white paper, textured like linen. The robes are practically seamless and non-irritating, easy to slip on, with no tie strings or snaps. The over-lap closure in the front and back makes one size fit all patients. The robes are non-opaque to x-rays. The disposable feature saves laundering, handling and mending and eliminates the possibility of cross infection since they are designed to be worn once. **Disposa Products Corp., Dept. MH, 220 E. 42nd St., New York 17. (Key No. 445)**

Garbage Disposer

Designed specifically for institutional use is the new heavy duty Herlex Model 1100 garbage disposer. Extremely compact in size, it is less than 2 feet in diameter.

A new principle of grinding is incorporated into the new disposer which permits large capacity with fine grind, discharging waste into the sewage system as flowing liquid. The new unit is equipped with a heavy duty 5 h.p. motor and has a cast aluminum, non-corrosive housing. The disposer has a built-in "silver saver" to prevent silver from entering the grinding area of the machine. Model 1100 is engineered for continuous operation, is designed to meet rigid requirements of food waste disposal conditions, is easily installed, using standard plumbing fittings, and is readily adaptable to a variety of installation requirements. **Herlex Mfg. Co., Dept. MH, 1442 W. Van Buren St., Chicago 7. (Key No. 446)**

Cadet Floor Scrubber

The improved Lincoln Cadet floor scrubber has interchangeable attachments for waxing and polishing floors and for scrubbing rugs. It has an increased capacity ¼ h.p. continuous duty type motor with large reservoirs for complete lubrication over long periods of operation, an improved gear reduction unit, and a top grade lubricant with a new seal to prevent leakage of lubricant or entrance of foreign matter into the gear case.

The new floor and rug maintenance unit is designed to meet the need for a small, light weight, single disc unit that will handle heavy duty maintenance for small institutions or one department of the large institution. The wheel carriage has been redesigned. **Lincoln-Schlueter Floor Machinery Co., Dept. MH, 1250 W. Van Buren St., Chicago 7. (Key No. 447)**

Water Cooling System

A completely packaged circulating system for supplying clear, chlorine-free water in buildings to as many as 300 drinking stations has recently been announced. The compact new unit can supply multi-story buildings as well as large-area buildings with up to 400 gallons per hour of 50 degree water. It also generates up to 150 gallons reserve chilled water to meet extra heavy demands at special periods.

Smaller models of this compact unit, which is designed to reduce installation time and cost, are available suitable for from three outlets up, having the same ratio of storage to capacity and affording the advantages of economy of installation and operation. A Filter-Rectifier assembly guards against varying conditions, eliminating tastes and odors and removing microscopic particles of rust, algae and sediment of all kinds to ensure clear, palatable water. The Packaged, Central Circulating System is designed for fast hook-up to power, water and return connections. **Filtrine Mfg. Co., Dept. MH, 53 Lexington Ave., Brooklyn 5, N. Y. (Key No. 448)**

Automatic Controls

The Lawler Water Pressure Equalizers are designed to maintain equal pressures in the hot and cold water lines to the fixtures, regardless of any variance in pressures in the supply lines. When there is a sudden demand for hot or cold water, there will be a decided pressure drop on the line in use. The Lawler Water Pressure Equalizer immediately counteracts this change, closing down on the higher pressure line and at the same time increasing the opening of the lower pressure line. It is especially practical where there are shower installations and other installations such as scrub-up rooms where pre-set water temperatures must be held stable. **Lawler**

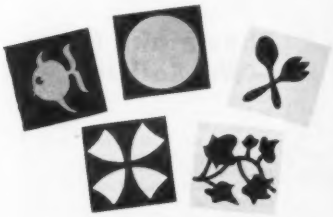
Automatic Controls, Inc., Dept. MH, 453 N. MacQuesten Pkwy., Mt. Vernon, N. Y. (Key No. 449)

EASIER CLEANING...
LOWER MAINTENANCE
COSTS WITH

KENTILE
RUBBER TILE

Kentile Rubber Tile is so easy to keep spotlessly clean. The tough, durable surface resists dirt, grime and stain . . . and each precision-made tile fits tightly against its neighboring tile to eliminate unsightly, hard-to-clean cracks and crevices. Cleaning time and expense are cut to a minimum.

Due to its remarkable construction, Kentile Rubber Tile always looks polished, gleaming smooth. And the cushioning action of these hospital-quiet floors softens every footstep . . . quiets every sound . . . give colorful beauty and wear throughout years of constant hard service.



For custom-designed beauty in special rooms choose *ThemeTile* decorative inserts available only with Kentile Rubber Tile. They can be installed with no added labor expense and serve both a decorative and a functional purpose.

Kentile Rubber Tile Floors go down rapidly . . . economically . . . tile by tile without interruption to important hospital routines.

For further information and accurate estimates, consult your local Kentile Dealer. His name is listed under FLOORS in the classified phone directory.

KENTILE
***RUBBER TILE*®**

KENTILE, INC., 58 Second Avenue, Brooklyn 15, New York • 350 Fifth Avenue, New York 1, N. Y. • 705 Architects Building, 17th and Sansom Streets, Philadelphia 3, Pennsylvania • 1211 NBC Building, Cleveland 14, Ohio • 225 Moore Street, S.E., Atlanta 2, Georgia • 2020 Walnut Street, Kansas City 8, Missouri • 1440 11th Street, Denver 4, Colorado • 4532 South Kolin Avenue, Chicago 32, Illinois • 1113 Vine Street, Houston 1, Texas • 4301 Santa Fe Avenue, Los Angeles 58, California • 95 Market St., Oakland 4, Calif. • 452 Statler Building, Boston 16, Mass.

Pharmaceuticals

Dia-Discs

Dia-Discs are small diagnostic tablets containing measured amounts of antibiotics and are used for the purpose of determining the antibiotic to which an infectious organism is most sensitive. Six different Dia-Discs are available: penicillin, bacitracin, streptomycin, Chloromycetin, aureomycin and Terramycin. Two potencies of each antibiotic are supplied to ensure accuracy over the entire range of sensitivity. Dia-Discs are supplied in boxes of 24, each tablet individually sealed in pliofilm, and are available as a unit in a convenient box, together with a Sensitivity Chart designed to enable the technician to interpret quickly the findings observed. **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 450)**

Truozine

Truozine is available in the form of Truozine Dulcet Tablets, 0.3 Gm., Truozine Tablets, 0.5 Gm., grooved, and Truozine Suspension. Each product contains sulfadiazine, sulfamerazine and sulfamethazine. Dulcet Tablets are green, aromatic, candylike sugar tablets which may be chewed or crushed and given in a half teaspoonful of water. Truozine Suspension is a mint-flavored aqueous suspension. The product offers the combined therapeutic effects of the three component sulfonamide drugs with reduced danger of crystalluria and renal damage. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 451)**

Ferrophyll

Ferrophyl is a new hematinic for rapid and sustained response in hypochromic or secondary anemias. The product contains exsiccated ferrous sulfate, sodium potassium copper chlorophyllin and vitamin B_{12}. Studies have indicated more rapid hemoglobin regeneration when chlorophyll is combined with iron therapy, hence the formula. Ferrophyl is supplied in bottles of 50 tablets. **Lakeside Laboratories, Inc., Dept. MH, 1707 E. North Ave., Milwaukee 2, Wis. (Key No. 452)**

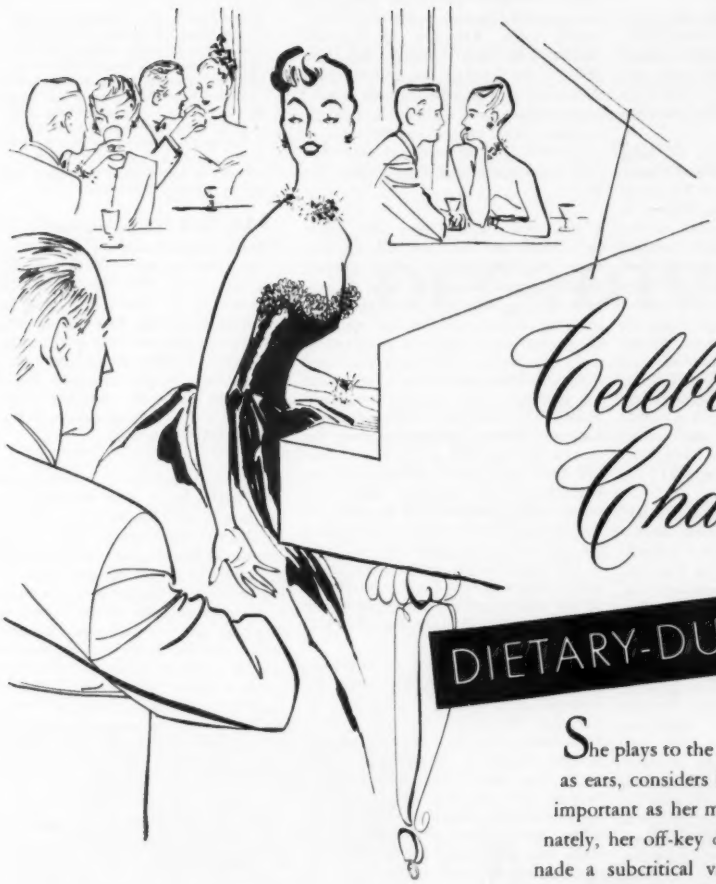
Chloresium Tablets

Chloresium Tablets are a new lozenge-type chlorophyll deodorizing tablet designed to provide effective control of mouth, breath and body odors. Containing highly concentrated, purified water-soluble chlorophyll in an active and palatable form, Chloresium Tablets permit prolonged retention in the mouth, thus ensuring elimination of mouth odors for many hours. The saliva in which the tablets dissolve acts as a buffer and prevents inactivation of the chlorophyll. **Rystan Company, Inc., Dept. MH, Mt. Vernon, N. Y. (Key No. 453)**

Cremomethazine

Cremomethazine is a cherry-lime flavored suspension of soluble sulfamethazine for systemic and urinary tract infections. It is a palatable product of particular interest to the pediatrician who desires a relatively safe, single sulfonamide easily administered to children. It is also useful in pneumonia, meningitis, gonorrhea and prevention of recurrences of rheumatic fever.

Sulfamethazine is a soluble systemic sulfonamide in tablet form which has one more methyl group in its molecule than sulfamerazine. It is absorbed more rapidly than sulfadiazine and is excreted more quickly than selfamerazine or sulfadiazine. Cremomethazine is supplied in "Spasaver" pint bottles. Sulfamethazine Tablets are supplied in bottles of 100 and 1000. **Sharp & Dohme Inc., Dept. MH, 640 N. Broad St., Philadelphia 30, Pa. (Key No. 454)**



Celebrated Chanteuse

DIETARY-DUB!

She plays to the customers' eyes as well as ears, considers her bathroom scales as important as her musical scales. Unfortunately, her off-key dieting may soon serenade a subcritical vitamin deficiency. For deficiencies of the B complex, many physicians prescribe SUR-BEX as supplemental therapy to a corrected diet. With the addition of vitamin B_{12}, SUR-BEX now supplies six B complex factors in a well-balanced formula—yet triple-coated SUR-BEX tablets are good tasting, easy to swallow.

The same potent B complex formula, *plus* five times the minimum daily requirement of ascorbic acid, is supplied by SUR-BEX WITH VITAMIN C tablets. Both tablet forms are supplied in bottles of 100, 500 and 1000. For patients who dislike tablets, a new liquid form—SUR-BEX SYRUP—is now available. A therapeutic formula in pleasant-tasting form. Supplied in 1-pint and 1-gallon bottles. **Abbott**

Each SUR-BEX Tablet contains:

Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} (as vitamin B_{12} concentrate)	2 mcg.
Pantothenic Acid (as calcium pantothenate)	10 mg.
Liver Fraction 2, N.F.	0.3 Gm. (5 grs.)
Brewer's Yeast, Dried	0.15 Gm. (2½ grs.)

Sur-bex with Vitamin C contains 150 mg. of ascorbic acid in addition to the vitamin B complex factors above.

Product Literature

• Solution Aerolin Compound, cyclopentamine and aludrine compound, Lilly, for treatment of asthma, status asthmaticus and emphysema, is discussed in a booklet recently published by Eli Lilly & Co., Indianapolis 6, Ind. **(Key No. 455)**

• A portfolio of information on **Solid Kumfort Magnesium and Wood Chairs That Fold** has been issued by Louis Rastetter & Sons Co., Fort Wayne 1, Ind. The portfolio gives data on the multiple use of rooms, correct spacing for table and auditorium seating, illustrates actual use of the chairs, provides diagrams of floor space to show how it may be used to best advantage, and gives complete catalog information on two upholstered Magnesium chairs and nine wood models, all with Rastetter hinge and brace construction for strength and long life under severe use. A complete line of folding card tables and folding extension tables as well as card table sets is also shown. **(Key No. 456)**

• "Package Plan" laundry units for hospitals, sanitariums and similar institutions are outlined in a booklet, **"A Guide to Laundry Savings,"** issued by The Paul T. Wiegand Laundry Machinery Co., 143 Perry St., Buffalo 4, N. Y. **(Key No. 457)**

• **"Corbin Wood Products"** illustrated and described in a new folder issued by Corbin Cabinet Lock, Wood Products Division, The American Hardware Corp., New Britain, Conn., cover mail sorting tables, storage cabinets, key cabinets, bulletin boards and other items constructed of kiln-dried hardwoods. The products are offered for shipment knocked-down, complete with all hardware needed for re-assembly. **(Key No. 458)**

• The convenience, economy and other advantages of **"Trouble Saver" Sectional Tubular Steel Scaffolding** for maintenance work, both indoors and outdoors, are discussed in a new 12 page **Bulletin PSS-24** issued by the Patent Scaffolding Co., Inc., 38-21 Twelfth St., Long Island City 1, N.Y. The text is illustrated by photographs and line drawings on erection and dismantling of basic units, available frames and components, actual applications and other subjects. **(Key No. 459)**

• A full-line catalog of Sturtevant Division equipment has been released by Westinghouse Electric Corp., Sturtevant Division, 200 Readville St., Boston 36, Mass. Equipment for cooling, heating, dehumidifying, cleaning, filtering and circulation of air is covered in the 16 page **Catalog SA-6692. (Key No. 460)**

• An attractive and colorful booklet on Tomac Infanette Nursery Equipment has been prepared by the American Hospital Supply Corp., Evanston, Ill. Entitled, **"Don't Let Your Nursery Sell You Short!"** the booklet is entertainingly illustrated with sketches as well as with illustrations of the equipment. Full descriptive details are included on the various articles of equipment and actual hospital installations are pictured. **(Key No. 461)**

• Two new catalogs have been issued by Certain-teed Products Corp., Ardmore, Pa. The first, covering **gypsum sheathing and walboards,** is a 20 page book giving detailed instructions for applying sheathing and the various types of gypsum wallboard and describes in detail the laminated gypsum wallboard system and the fiber tape joint system for treating joints between wallboard panels. The second is a 36 page **Gypsum Lath and Plaster Catalog** describing the various gypsum lath products and base and finish coat plasters manufactured by Certain-teed. A reference chart lists many of the problems met by plasterers and their remedies. Basic specifications for application of plaster on all types of lath and masonry surfaces, a dictionary of plastering terms and a description of the manufacturing of gypsum lath and plaster are included. **(Key No. 462)**

• A new 16 page catalog on **Operating Room Equipment in Stainless Steel** has been published by S. Blickman, Inc., 536 Gregory Ave., Weehawken, N.J. Over 50 different units are illustrated and described including instrument stands, stools, foot stools, waste receivers, kick buckets, linen hampers, irrigator stands, dressing drums, instrument tables, biopsy tables, work tables, glove and sponge racks and other equipment. Complete specifications are included for each unit. All equipment listed is furnished with Underwriters' approved electrically conductive casters and floor tips. **(Key No. 463)**

• **"Apparatus, Reagents and Chemicals for Clinical Procedures"** are described in a new catalog released by Standard Scientific Supply Corp., 34 W. 4th St., New York 12. The 168 page catalog is divided into eight sections covering Reagents listed alphabetically, Chemicals, Reagents listed by procedures, Standards and Buffers, Reagents and Stains, Dyes, Culture Media and Apparatus. **(Key No. 464)**

• The **Spring 1951 catalog of Lea & Febiger Books** on medicine, pharmacy, nursing and related subjects is now available from Lea & Febiger, Washington Square, Philadelphia 6, Pa. **(Key No. 465)**

Methods Manuals

Because much of the literature received by the editor of *"What's New"* is of a guidance or reference nature, as differentiated from catalog and other actual product literature, a new section of the *"What's New"* department has been set up. Under **"Methods Manuals"** will be listed that literature which it is felt will be helpful to the administrator and his department heads in relation to operational, educational or public relations problems.

"Help With Your Community's Civil Defense Communications" is the title of a new brochure issued by General Electric Co., Dept. N-5, Electronics Park, Syracuse, N. Y. Presenting typical communications systems now in use which can be coordinated into a dependable emergency communications network in any community, the brochure also describes the company's technical advisory service for civil defense radio communications. **(Key No. 466)**

The second edition of **"Color Is How You Light It"** is now available from Sylvania Electric Products Inc., 87 Union St., Salem, Mass., at 50 cents a copy. Known as FL-420, the book is designed to enable those with lighting or decorating problems to predict how a color will look under any one of the eight colors of white light now available. The second edition includes analyses of the two new de luxe colors of fluorescent white light perfected since publication of the first book two years ago. Colors in the new book are separated into five groups of eight colors each, according to the light under which they appear most favorable. **(Key No. 467)**

The PC Daylighting Nomograph is designed to make possible the prediction of daylighting levels in a room before the building is constructed. The device was developed at the Pittsburgh Corning Daylighting Research Center and is available from Pittsburgh Corning Corp., 307 Fourth Ave., Pittsburgh 22, Pa. Through the careful study of functional glass block and window performance in existing buildings and in the laboratory under a wide variety of conditions, the data was compiled which served as a basis for the PC Daylighting Nomograph. With the aid of this device the amount of daylight which will be present at any point in a room, and at any time of day and day of the year can be predicted. The effects of building orientation and geographical location, fenestration area, sun altitude and azimuth, clouds and the like are accounted for. The information required to make the prediction can be obtained from the architect's plans and the local weather bureau records. The Nomograph is offered without charge. **(Key No. 468)**

"They Also Serve" is the title of a motion picture produced for the American Medical Association by The Jam Handy Organization, 2821 E. Grand Blvd., Detroit 11, Mich. The project was supported by a grant from the Becton-Dickinson Foundation, is a 17 minute black and white production, and features the importance of the individual physician in local civilian defense programs and the need for integrating community programs with state and national planning. **(Key No. 469)**

"Modern Methods of Preparing Baby's Formula" is the title of a manual offered by The Pyramid Rubber Co., Ravenna, Ohio. The booklet gives all steps from equipment needed and washing and sterilizing equipment, to feeding the baby. **(Key No. 470)**

"The Care and Handling of Glass Volumetric Apparatus" is the title of a new booklet containing accurate basic information for scientific and clinical laboratories and for advanced students in chemistry. The booklet discusses the proper handling, care and calibration of volumetric glassware and affords an opportunity for laboratory technicians to add to the life of their equipment by proper handling. The result of months of research and preparation, the manual is offered by Kimble Glass Division of Owens-Illinois Glass Co., P. O. Box 1035, Toledo 1, Ohio. It contains 16 colored figures and six tables describing systems of weights and measure, cleaning apparatus, reading the meniscus, gravimetric and volumetric calibration and the drainage time of burettes and pipettes. **(Key No. 471)**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 414 Room Grouping
- ☐ 415 Swivel Yarn Sweeper
- ☐ 416 Single Pedestal Overbed Table
- ☐ 417 Wood Room Group
- ☐ 418 Metal Catheter Tip Syringe
- ☐ 419 Food Conveyor
- ☐ 420 Heavy-Duty Steam Gun
- ☐ 421 Seriograph
- ☐ 422 Acousti-Celotex Finish
- ☐ 423 Dry Chemical Extinguisher
- ☐ 424 Disposable Oxygen Mask
- ☐ 425 Ritter Proctologic Table
- ☐ 426 Fiberglas Fabrics
- ☐ 427 Multi-Purpose Uniforms
- ☐ 428 Upholstery Shampoo Machine
- ☐ 429 Precooked Cereal
- ☐ 430 Uni-Mac Laundry Unit
- ☐ 431 Mobile Kardex
- ☐ 432 Improved Garland Broiler
- ☐ 433 Ice Cube Machine
- ☐ 434 Magic Chef Line
- ☐ 435 Joanna Wall Covering
- ☐ 436 Steam Pressure Cooker
- ☐ 437 Pneolator
- ☐ 438 Sterilwrap
- ☐ 439 Diagnostic Kit
- ☐ 440 Bed Elevator
- ☐ 441 Air Diffuser
- ☐ 442 Pillow Reception Radio
- ☐ 443 Seal and Varnish Stripper
- ☐ 444 Toilet Tissue Holder
- ☐ 445 Disposable Patient Robes
- ☐ 446 Garbage Disposer
- ☐ 447 Cadet Floor Scrubber
- ☐ 448 Water Cooling System
- ☐ 449 Water Pressure Equalizers
- ☐ 450 Dia-Discs
- ☐ 451 Truozine
- ☐ 452 Ferrophyll
- ☐ 453 Chloresium Tablets
- ☐ 454 Cremomethazine
- ☐ 455 "Solution Aerolin Compound"
- ☐ 456 Chair Portfolio
- ☐ 457 "Guide to Laundry Savings"
- ☐ 458 "Corbin Wood Products"
- ☐ 459 Bulletin PSS-24
- ☐ 460 Sturtevant Equipment
- ☐ 461 Nursery Booklet
- ☐ 462 Gypsum Catalogs
- ☐ 463 Operating Room Catalog
- ☐ 464 Laboratory Catalog
- ☐ 465 Book Catalog
- ☐ 466 "Civil Defense"
- ☐ 467 Color Booklet
- ☐ 468 Daylighting Nomograph
- ☐ 469 "They Also Serve"
- ☐ 470 "Baby's Formula"
- ☐ 471 Laboratory Glassware Manual
- ☐ 472 Application Manual
- ☐ 473 Cooking Chart
- ☐ 474 Book Announcement
- ☐ 475 Book Announcements

I should also like to have information on the following products

_____

_____

NAME _____ TITLE _____

HOSPITAL _____

STREET _____

CITY _____ ZONE _____ STATE _____

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

A 32 page manual giving helpful information required in the selection and application of radiation heating equipment for steam or hot water systems has been prepared by C. A. Dunham Co., 400 W. Madison St., Chicago 6. Entitled **Application Manual No. 1295,** the booklet is a guide for specifying and installing Convector, Baseboard and Fin-Vector Radiation. Procedure for selecting radiation is graphically illustrated with sample capacity tables. Diagrammatic sketches plus engineering data show how to rough in piping for a typical baseboard installation. **(Key No. 472)**

The new **John Van Range Steam Cooking Chart and Time-Table** gives specific information on steam cooking of 81 items, from apples to turnips. The chart includes the number of minutes in the steamer, whether non-pressure or pressure, as well as the recommendation as to the type of pan in which the food is to be placed in the steamer. The chart is designed for those concerned with mass feeding in institutions and is available from The John Van Range Co., 401 Eggleston Ave., Cincinnati 2, Ohio. **(Key No. 473)**

Book Announcements

"Directory of Biological Laboratories," 5th ed., including more than 1000 laboratories in the United States and Canada as well as individuals and firms in consulting and research and independent research organizations. 164 pp., $3. **Burns Compiling & Research Organization, Dept. MH, 200 Railway Exchange Bldg., Chicago 4. (Key No. 474)**

Alvarez, "The Neuroses," 667 pp., $10. Millard and King, "Human Anatomy and Physiology," 3rd ed., 596 pp., $4.25. "Collected Papers of the Mayo Clinic and the Mayo Foundation," 1951 ed., including a symposium of 12 articles on ACTH and Cortisone, 812 pp., $11.50. **W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 475)**

Suppliers' News

General Electric X-Ray Corporation, 4855 Electric Ave., Milwaukee 14, Wis., manufacturer of x-ray equipment, and an affiliate of the General Electric Company, has become a department of the parent organization. **John H. Smith,** president of General Electric X-Ray Corporation, has become general manager of the new department. All marketing and other functions of General Electric X-Ray will remain unchanged.

Physicians' Record Co., 161 W. Harrison St., Chicago 5, suppliers of record forms for hospitals, announces the election of **John W. Voller Sr.** as president of the company.

Printed in U.S.A.

Around the Wards with Kellogg's

Patient CLARK De-licious! My favorite breakfast to make me feel right at home! (Right! Kellogg's cereals are a tasty treat. Kellogg's cereals are favorites with kids and grown-ups the country over.)

Nurse DOUGHERTY I don't know what I'd do without Kellogg's Individuals. They save me time—there's a choice for everyone—and what a cinch to serve!

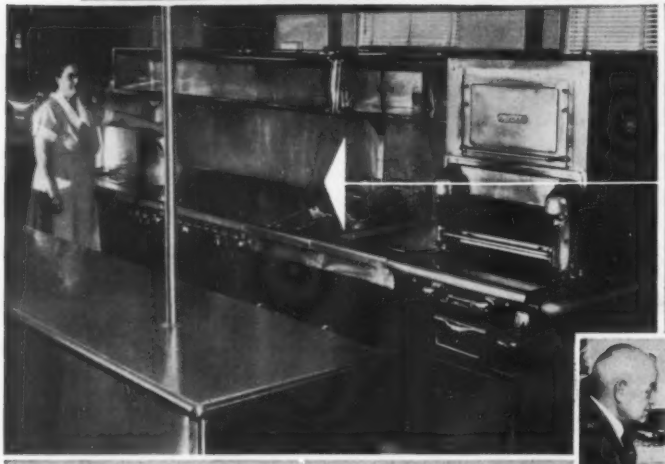
Dietitian BROWN Breakfast planning is so much easier with Kellogg's big assortment of flakes, shredded and popped cereals. And they're healthful too—all either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

KELLOGG'S NEW INDIVIDUAL PACKAGE IS EASY TO USE *2 WAYS!*

Just take the box in both hands and break open the top along the perforated line as shown. That's all there is to it! A perfect portion every time! (And for extra fun, eat right out of the package—just open the little perforated doors on the back of the box and pour the milk right on!) Either way, Kellogg's new Individual Box is CONVENIENT FOR YOU!

KELLOGG'S CORN FLAKES • RICE KRISPIES • PEP • KELLOGG'S 40% BRAN FLAKES • CORN-SOYA
KRUMBLES • KELLOGG'S SHREDDED WHEAT • KELLOGG'S RAISIN BRAN FLAKES • ALL-BRAN

Modern 300-bed Mercy Hospital, Springfield, Ohio, serves 1500 Gas-cooked meals a day.



Hospital employee, Mrs. Stott, in Main Kitchen. Modern Gas Equipment includes:

- 3 Garland Hot Top Ranges
- 2 Garland Roasting Ovens
- 2 Pitco Frialators
- 1 Garland Broiler

Sister Mary Leah, Dietitian, and Sister Mary Anselm receive 1950 Honor Award plaque from Mr. O. T. Carson. Plaque reads: "For Highest Standards of Sanitation and for superlative Achievement in Storing, Handling, Preparing and Serving Food."

modern GAS kitchens

feature cooking speed and flexibility at Mercy Hospital

Sister Mary Leah R.S.M., Dietitian of Springfield's Mercy Hospital says:

"I know that the *speed* and *flexibility* of our Modern Gas Equipment make it possible for our busy food department to keep on schedule regardless of type of diets required."

In addition to the main kitchen, Mercy Hospital is equipped with a Special Diets Gas Kitchen, 2 Cafeterias featuring Modern Gas Equipment, and a Coffee Shop utilizing Gas for food preparation. Gas cooking is clean . . . fast . . . economical . . . and versatile, to meet the fluctuating demands of hospital service.

For optimum efficiency and economy in Volume food preparation, check the values of Modern Blue Flame Gas Cooking with your Gas Company Representative. Call him today.

MORE AND MORE... THE TREND IS TO GAS FOR COMMERCIAL COOKING

AMERICAN GAS ASSOCIATION • 420 LEXINGTON AVENUE • NEW YORK 17, NEW YORK

PREFERRED

for ALL BAKED DISHES


PLAIN WELSH RAREBIT


EXTRA DEEP BAKER

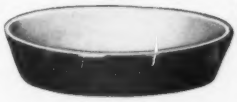

RAMEKIN

POT PIE


SERVING OR SOLE DISH


FRENCH WELSH RAREBIT


FRENCH SHIRRED EGG


FORT PITT BAKER


COCOTTE


SCALLOPED RAMEKIN


BAKING SHELL


AU GRATIN OR SHIRRED EGG


CRAB SHELL

Hall Baking Dishes are available in sizes ranging from individual to banquet service.

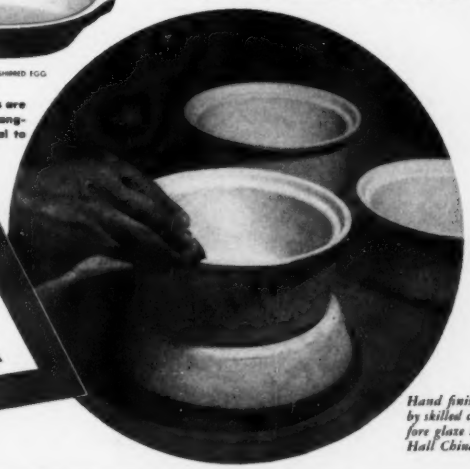
The heavy, dense walls of Hall China make perfect baking easy. Hall bakers cannot craze . . . are pure white inside and they stay that way because they are made by an exclusive process that fuses body, glaze, and color inseparably.

Write on company letterhead for Catalog 48, which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

HALL
Secret Process
FIREPROOF CHINA



Hand finishing—done by skilled craftsmen before glaze is applied to Hall China.

LEONARD SCHULTZE & ASSOCIATES
architects

EDWARD E. ASHLEY
consulting engineer

STARRETT BROTHERS & EKEN, INC.
general contractors

C. H. CRONIN, INC.
plumbing contractor

NEW YORK PLUMBERS' SPECIALTIES CO., INC.
plumbing wholesaler

CROWELL-COLLIER magazines bear names well known in homes throughout our forty-eight states, and in Canada and overseas.

BELGIAN BLACK MARBLE WHERE ONCE EMBROIDERED VELVET HUNG

On the site of the old 58-room Vanderbilt mansion on New York's famed Fifth Avenue now stands the impressive headquarters of CROWELL-COLLIER, publishers of *a million magazines daily*. Inside the entrance, the shining black marble walls of today are in direct contrast with the rich red hangings that once adorned the Vanderbilt reception room. Typical of the modernity of this new building is an elevator control which automatically adjusts to traffic flow conditions. Likewise typical of highest standards was the selection of SLOAN FLUSH VALVES for installation throughout the building—another evidence of preference that explains why . . .

more **SLOAN *Flush* VALVES**
are sold than all other makes combined

SLOAN VALVE CO. • CHICAGO • ILLINOIS

The SLOAN ACT-O-MATIC SHOWER HEAD is automatically self-cleaning each time it is used! No clogging. No dripping. When turned on it delivers a cone-within-cone spray of maximum efficiency. When turned off it drains instantly. It gives greatest bathing satisfaction, and saves water, fuel and maintenance service costs.